

**Statewide Medicaid Managed Care (SMMC)
Managed Care Plan
Report Guide
01-01-14**

(For use with the Long-term Care Managed Care Plan Contract, NOT for use with the 2012-15 Medicaid Health Plan Contract)

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Section One: Overview and Reporting Requirements

Chapter 1: General Overview

Purpose of Report Guide

The Report Guide is a companion to each SMMC Managed Care Plan's Contract (Contract) with the Agency for Health Care Administration (Agency or AHCA). It provides details of plan reporting requirements including instructions, templates, and submission directions.

This Report Guide provides report guidance and requirements for the following types of SMMC program Managed Care Plan Contracts:

- ✓ Capitated Managed Care Plan Contracts
- ✓ Fee-for-Service Provider Service Network (FFS PSN) Contracts

For the above contract types, this Report Guide currently covers the following SMMC plan types:

- ✓ LTC Health Maintenance Organizations (LTC HMOs)
- ✓ LTC Capitated Provider Service Networks (LTC Capitated PSNs)
- ✓ LTC Fee-for-Service Provider Service Networks (LTC FFS PSNs)

Note: The Report Guide will be revised to include Managed Medical Assistance (MMA) plan types, reporting requirements and information prior to contracting of the MMA Managed Care Plans. This edition of the Report Guide solely reflects the requirements of LTC Managed Care Plans. This Report Guide is NOT for use with the 2012-15 Medicaid Health Plan Contract. The Report Guide for the 2012-15 Medicaid Health Plan Contract is located at:

http://ahca.myflorida.com/MCHQ/Managed Health Care/MHMO/med_prov_0912.s.html

Chapter 2, General Reporting Requirements, covers the general AHCA report submission and certification requirements for the SMMC Managed Care Plans. After these introductory chapters, the remaining chapters cover any specific report certification information and specific individual report instructions and formats.

The individual report chapters are organized with the LTC Contract Attachment II, Core Contract Provisions (**CORE**) reports appearing first, followed by LTC Contract Attachment II, Exhibits reports appearing second, both in respective alphabetical order. The designation **CORE** indicates that the contract requirement for the report appears in

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the **CORE** of the Managed Care Plan's Contract. The designation **LTC** indicates that the contract requirement for the report appears in the Exhibits of the Managed Care Plan's Contract.

Within each individual report chapter, the following report-specific items are covered:

- Managed Care Plan types that are required to provide the report.
- Report purpose.
- Report frequency requirements and due dates.
- Report submission requirements.
- Specific instructions and requirements for completion, including format and any variances specific to a particular Managed Care Plan type.
- Report template.

Reading this Report Guide should produce the following four results:

- An understanding of the Managed Care Plan's responsibility for report submissions.
- A clear concept of what each report requires and how it is best fulfilled.
- A specific report format to maintain consistency in the data flow.
- A single location for all format requirements for all contractual non-X-12 reports that must be submitted by Managed Care Plans to the Agency.

This Report Guide is referenced in each Managed Care Plan's Contract with the Agency and each report is summarized in the Contract's Summary of Reporting Requirements Table.

The Managed Care Plans shall comply with all reporting requirements set forth in its Contract and this Report Guide. All of the reports within the Report Guide are a contractual obligation of the Managed Care Plan to the Agency, and the Managed Care Plans are responsible for their accurate completion and timely submission as specified in the Contract and Report Guide. Non-compliant Managed Care Plans are subject to liquidated damages and sanctions as specified in the Contract.

Note: In general, the report submission requirements in the Report Guide are for Managed Care Plans that have begun providing services under Statewide Medicaid Managed Care (SMMC). Managed Care Plans are not required to submit the reports as specified in this Report Guide prior to providing services under the

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SMMC LTC Contract unless the specific report is required to be submitted prior to the provision of services.

Report Guide Updates

As specified in each Managed Care Plan Contract, the Agency reserves the right to modify reporting requirements with a 90-calendar-day written notice to the Managed Care Plan, unless otherwise specified. The Agency will post updates to the Report Guide on the AHCA LTC Plan Readiness website at:

http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml#ltpcr

In general, the Report Guide may change on a calendar quarter basis. Changes in templates between Report Guide postings are provided on the website. The latest revised version of the Report Guide will be displayed with its effective date, along with a Report Guide Revisions Transmittal, and a summary of changes made to the original document.

Summary Table of Managed Care Plan Reports (non X-12 Reports)

The table below lists the following Managed Care Plan reports required by the Agency. These reports must be submitted as indicated in the Summary of Reporting Requirements table (below) and as specified in the SMMC Report Guide and the LTC Managed Care Plan Contract. Please refer to this table as needed. Additional reporting requirements are specified in the LTC Managed Care Plan Contract.

SUMMARY OF REPORTING REQUIREMENTS TABLE

Managed Care Plan reports required by the Agency and included in this Report Guide are as follows:

Report Name	Contract Attachment II, Location; Report Guide Chapter	Plan Type	Frequency	Submit To
Community Outreach Health Fairs/Public Events Notification	Section IV. B.4.b. and Exhibit 12; Chapter 7	All LTC Plans	No later than the twentieth (20 th) calendar day of month before event month; amendments two (2) weeks before event	SMMC SFTP Site

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Report Name	Contract Attachment II, Location; Report Guide Chapter	Plan Type	Frequency	Submit To
Community Outreach Representative Report	Section IV.B.6.a. and Exhibit 12; Chapter 8	All LTC Plans	Two (2) weeks before activity; Quarterly, forty-five (45) calendar days after end of reporting quarter	SMMC SFTP Site
Provider Network File	Section VII and Exhibit 12; Chapter 12	All LTC Plans	Weekly, each Thursday by 5 p.m. EST	Choice Counseling Vendor SFTP Site
Provider Termination and New Provider Notification Report	Section VII and Exhibit 12; Chapter 13	All LTC Plans	Weekly, each Wednesday by 5 p.m. EST of the week following the report week	SMMC SFTP Site
Provider Complaint Report	Section VII and Exhibit 12; Chapter 11	All LTC Plans	Monthly within fifteen (15) calendar days after the end of reporting month	SMMC SFTP Site
Critical Incident Report	Section VIII and Exhibit 12; Chapter 9	All LTC Plans	Immediately upon occurrence and no later than within twenty-four (24) hours of detection or notification	LTC MCP Contract Manager via email
Critical Incident Summary	Section VIII and Exhibit 12; Chapter 10	All LTC Plans	Monthly and rolled up for quarter and year — Due within fifteen (15) calendar days after the end of the reporting month	SMMC SFTP Site
Performance Measures Report - LTC	Section VIII and Exhibits 5, 8 and 12; Chapter 26	All LTC Plans	Annually, by July 1	SMMC SFTP Site
Enrollee Complaints, Grievance, and Appeals Report	Section IX and Exhibit 12; Chapter 20	All LTC Plans	Quarterly, within fifteen (15) calendar days after end of the reporting quarter	SMMC SFTP Site
Quarterly Fraud & Abuse Activity Report	Section X and Exhibit 12; Chapter 14	All LTC Plans	Quarterly, within fifteen (15) calendar days after the end of reporting quarter	OIG MPI Web-based Application Site

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Report Name	Contract Attachment II, Location; Report Guide Chapter	Plan Type	Frequency	Submit To
Annual Fraud and Abuse Activity Report	Section X and Exhibit 12; Chapter 4	All LTC Plans	Annually, by September 1	MPI-MC SFTP Site
Suspected/ Confirmed Fraud and Abuse Reporting	Section X and Exhibit 12; Chapter 15	All LTC Plans	Within fifteen (15) calendar days of detection	Agency's Online Electronic Data Entry Complaint Form
Claims Aging Report and Supplemental Filing Report	Section X and Exhibit 12; Chapter 6	All LTC Plans	Quarterly, forty-five (45) calendar days after end of reporting quarter; Capitated Plans, optional supplemental filing — one-hundred five (105) calendar days after end of reporting quarter	SMMC SFTP Site
Audited Annual and Unaudited Quarterly Financial Reports	Section XV and Exhibit 12; Chapter 5	All LTC Plans	Audited — Annually by April 1 for calendar year; Unaudited — Quarterly, forty-five (45) calendar days after end of reporting quarter	Single, non-secure email to MMCFIN@ahca.myflorida.com :
Administrative Subcontractors and Affiliates Report	Section XVI and Exhibit 12; Chapter 3	All LTC Plans	Quarterly within fifteen (15) calendar days of end of quarter	SMMC SFTP Site
Enrollee Roster and Facility Residence Report	Exhibits 3 and 12; Chapter 21	All LTC Plans	Monthly, due within fifteen (15) calendar days after the end of the reporting month	SMMC SFTP Site
Nursing Facility Transfer Report (Number of Enrollees Transitioned)	Exhibits 5 and 12; Chapter 23	All LTC Plans	Monthly, within fifteen (15) calendar day following the end of the report month	SMMC SFTP Site

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Report Name	Contract Attachment II, Location; Report Guide Chapter	Plan Type	Frequency	Submit To
Denial, Reduction, Termination of Services Report	Exhibits 5 and 12; Chapter 19	All LTC Plans	Monthly, due fifteen (15) calendar days after the end of the reporting month	SMMC SFTP Site
Utilization Reporting: <ul style="list-style-type: none"> Home and community-based services (HCBS) Nursing facility Hospice Identification of HCBS enrollees not using services	Exhibits 5 and 12; Chapter 27	All LTC Plans	Quarterly with Annual Roll-up — due within thirty (30) calendar days of the end of the reporting quarter	SMMC SFTP Site
Participant Direction Option (PDO) Roster Report	Exhibits 5 and 12; Chapter 24	All LTC Plans	Monthly due within fifteen (15) calendar days after the end of the reporting month	SMMC SFTP Site
Case Management File Audit Report	Exhibits 5 and 12; Chapter 16	All LTC Plans	Quarterly — due within thirty (30) calendar days of the end of the reporting quarter	SMMC SFTP Site
Case Management Monitoring and Evaluation Report	Exhibits 5 and 12; Chapter 17	All LTC Plans	Quarterly with annual roll-up — due within thirty (30) calendar days of the end of the reporting quarter	SMMC SFTP Site
Case Manager Caseload Report	Exhibits 5 and 12; Chapter 18	All LTC Plans	Monthly, within fifteen (15) calendar days after the end of the reporting month	SMMC SFTP Site
Missed Services Report	Exhibits 5 and 12; Chapter 22	All LTC Plans	Monthly, due thirty (30) calendar days after the end of the reporting month	SMMC SFTP Site
Patient Responsibility Report	Exhibits 12 and 15; Chapter 25	All LTC Plans	Annually, by October 1 for the prior Contract year	SMMC SFTP Site

Chapter 2: General Reporting Requirements

General Report Certification Requirements

In addition to the specific report requirements found in subsequent chapters, all Managed Care Plans are responsible for fulfilling basic requirements that apply to all submissions. These include submitting an attestation assuring the accuracy, completeness, and timely submission of each report.

Some chapters have designated file names and/or formats for these federally required attestations (also referred to as “certifications”). However, for chapters where a file name and/or format is not designated, Managed Care Plans must create and submit a PDF file with a file name that includes the word “attestation” and the date it is being submitted. The attestation can simply state:

“I, <<NAME OF PLAN OFFICIAL>>, certify that all data and all documents submitted for <<Report Name and Report Period>> are accurate, truthful, and complete to the best of my knowledge, and that all documents submitted are accurate, truthful, and complete.”

The page should be on the plan’s letterhead, signed by the official referenced on the attestation itself, and it should include the official’s specific title. The attestation PDF file should be submitted to the same person, location, and in the same manner as the report submission unless the specific report chapter indicates otherwise.

The Managed Care Plan shall submit its attestation at the same time it submits the certified data reports (see 42 CFR 438.606(c)). The attestation (and delegation of authority if applicable) must be scanned and submitted to the Agency as one PDF file. It shall be submitted with the certified data unless specifically indicated in the individual report chapters. A sample delegation of authority letter is provided by the Agency at:

http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml#ltcpr

Report Accuracy and Submission Timeliness

As specified in the Contract provisions, general reporting requirements include the following:

- The Managed Care Plan’s chief executive officer (CEO), chief financial officer (CFO) or an individual who directly reports to the CEO or CFO and who has delegated authority to certify the Managed Care Plan’s reports, shall attest, based on his/her best knowledge, information and belief, that all data submitted in conjunction with the reports and all documents requested by the Agency are accurate, truthful and complete (see 42 CFR 438.606(a) and (b)).

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- Deadlines for report submission referred to in the Contract provision is the actual time of receipt at the Agency bureau or location, not the date the file was postmarked or transmitted.
- If a reporting due date falls on a weekend or holiday, the report shall be due to the Agency on the following business day.
- All reports filed on a quarterly basis shall be filed on a calendar year quarter.

SMMC SFTP Site Access

Most reports are submitted to the Agency's SMMC SFTP site. To access the SMMC SFTP site, contact your Contract manager.

Report Naming and Identification

A report naming convention has been established for all reports and attestations (including supporting submission documents) with the following exceptions:

- Audited Annual and Unaudited Quarterly Financial Reports
- Provider Network File
- Quarterly Fraud and Abuse Activity Report
- Suspected/Confirmed Fraud and Abuse Reporting
- Reports submitted directly to the Agency's Fiscal Agent or other delegated entities outside of the Agency will maintain their own file naming convention.

This file naming convention is required in order to maintain submission validity, and to assist in Agency organizational efforts.

This file naming convention uses the plan name identifier as well as a unique 4-digit number assigned to each report, attestation and submission document. There are also codes for the report year, report year type and frequency of each report. These codes are provided in the Plan Identifier Table, Report Code Identifier Table, Report Year Type Table and the Frequency Code Table, respectively, later in this chapter. The plan name identifiers, report code identifiers, report year type identifiers and report frequency codes are all used as part of this SMMC file naming convention.

- The file naming convention is as follows:
 - The Managed Care Plan's three character identifier from the Plan Identifier Table
 - Four-digit year in which the report is due
 - Two-digit month in which the report is due
 - One-character identifier for the report's year type from the Report Year Type Table

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- One-character identifier for the report frequency from the Frequency Code Table
 - Two digits indicating the specific data period being reported from the Frequency Code Table (Reporting Data Period)
 - Four-digit report code identifier from the Report Code Identifier Table
- There are **NO** dashes, spaces or other characters between each field.
- File naming convention examples are provided at the end of this chapter.
- Most of the report file names not using this file naming convention require the use of the unique alphabetic 3-character plan identifier.
- For reports that require supplemental documents, the document should be submitted in a .zip file using the file naming convention for that report. This .zip file may not be password protected.
- Resubmitted or corrected filings must be submitted with the same file name as the original report. The only exception to this is if the resubmission is due to a correction needed for an incorrect file name; in this circumstance, the file name must be the correct file name using the correct file naming convention.
- **Late submissions** must be filed with the information required for the on-time filing. For example: a report due in July, but filed in August, must state the month of July (07) not August (08), in the file name. A report due in December 2013, but filed in January 2014, must state the year 2013 in the file name (not January 2014).

Any report that does not require this file naming convention shall have a designated file name which can be found within the individual Report Guide chapters, under the section labeled "Submission." Please submit all such reports and their accompanying attestations in the file formats designated within the "Submission" sections. It is important to follow the file naming designations specified in the individual report chapters in order to maintain submission validity.

Some reports will require the use of a two-digit numeric county code. The two-digit numeric county codes to be used for all such reports are provided for your convenience on the County Code Table in following pages.

General Submission and Size Limits

For all reports, in addition to following the designated file naming convention and format, other considerations should be taken:

1. The Managed Care Plan may not alter or change report templates in any way.

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2. For reports or documents emailed to the Agency, the Agency's email server security protocol allows documents with the ".zip" file extension; however, the file must be within the size limit listed in 3. below.
3. For reports or documents emailed to the Agency, there is a ten megabyte size limit on Agency servers. If larger files must be sent, the Managed Care Plan should discuss potential alternative delivery methods with its Agency Contract manager.

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PLAN IDENTIFIER TABLE*	
Plan Identifier	LTC Plan Name
AEC	America Elder Care
AMG	Amerigroup
COV	Coventry
HUM	Humana
MOL	Molina
SUN	Sunshine
URA	United

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Report Code Identifier Table				
SMMC Report Name	Report Code	Report Guide Chapter	Reporting Year Type	Submission Frequency
Administrative Subcontractors and Affiliates Report	0100	3	C	Quarterly
Administrative Subcontractors and Affiliates Report Attestation	0101			
Annual Fraud and Abuse Activity Report	0133	4	S	Annually
Annual Fraud and Abuse Activity Report Attestation	0134			
Case Management File Audit Report	0102	16	C	Quarterly
Case Management File Audit Report Attestation	0103			
Case Management Monitoring and Evaluation Report		17	C	Quarterly
<ul style="list-style-type: none"> Case Management Monitoring and Evaluation Report 	0104			
<ul style="list-style-type: none"> Case Management Monitoring and Evaluation Report Attestation 	0105			
<ul style="list-style-type: none"> Annual Roll-Up (4th Quarter Only) 	0106			
<ul style="list-style-type: none"> Annual Roll-Up Attestation 	0107			
Case Manager Caseload Report	0151	18	C	Monthly
Case Manager Caseload Report Attestation	0152			
Claims Aging Report & Supplemental Filing Report		6	C	Quarterly
<ul style="list-style-type: none"> Capitated Claims Aging Report 	0108			
<ul style="list-style-type: none"> Fee-for-Service Claims Aging Report 	0109			
<ul style="list-style-type: none"> Claims Aging Report Attestation 	0110			
<ul style="list-style-type: none"> Capitated Supplemental Filing Report 	0111			

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Report Code Identifier Table				
SMMC Report Name	Report Code	Report Guide Chapter	Reporting Year Type	Submission Frequency
<ul style="list-style-type: none"> Supplemental Filing Report Attestation 	0112			
Community Outreach Health Fairs/Public Events Notification		7	C	Variable/ Monthly
<ul style="list-style-type: none"> Community Outreach Health Fairs/Public Events Notification Report 	0113			
<ul style="list-style-type: none"> Amendment to a reported event change 	0114			
<ul style="list-style-type: none"> Community Outreach Health Fairs/Public Events Notification Report Attestation 	0115			
Community Outreach Representative Report	0116	8	C	Variable/ Quarterly
Community Outreach Representative Report Attestation	0117			
Critical Incident Report	0118	9	C	Variable
Critical Incident Report Attestation	0119			
Critical Incident Summary Report	0120	10	C	Monthly
Critical Incident Summary Report Attestation	0121			
Denial, Reduction, or Termination of Services Report	0125	19	C	Monthly
Denial, Reduction, or Termination of Services Report Attestation	0126			
Enrollee Complaints, Grievances, and Appeals Report	0127	20	C	Quarterly
Enrollee Complaints, Grievances, and Appeals Report Attestation	0128			

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Report Code Identifier Table				
SMCC Report Name	Report Code	Report Guide Chapter	Reporting Year Type	Submission Frequency
Enrollee Roster and Facility Residence Report	0129	21	C	Monthly
Enrollee Roster and Facility Residence Report Attestation	0130			
Missed Services Report	0131	22	C	Monthly
Missed Services Report Attestation	0132			
Nursing Facility Transfer Report	0135	23		Monthly
Nursing Facility Transfer Report Attestation	0136			
Participant Direction Option (PDO) Roster Report	0137	24	C	Monthly
Participant Direction Option (PDO) Roster Report Attestation	0138			
Patient Responsibility Report	0139	25	K	Annual
Patient Responsibility Report Attestation	0140			
Performance Measures Report-LTC		26	C	Annually
<ul style="list-style-type: none"> • Performance Measures Report-LTC 	0141			
<ul style="list-style-type: none"> • Performance Measures Report Attestation 	0142			
<ul style="list-style-type: none"> • HEDIS Auditor Certification with Audit Review Table 	0143			
<ul style="list-style-type: none"> • Interactive Data Submission System (IDSS) file 	0144			
Provider Complaint Report	0145	11	C	Monthly
Provider Complaint Report Attestation	0146			
Provider Termination and New Provider Notification Report	0147	13	C	Weekly

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Report Code Identifier Table				
SMMC Report Name	Report Code	Report Guide Chapter	Reporting Year Type	Submission Frequency
Provider Termination and New Provider Notification Report Attestation	0148			
Utilization Report	0149	27	C	Quarterly
Utilization Report Attestation	0150			

Report Year Type Table	
Report Year Type	Report Year Period
K = Contract	09/01 – 08/31
F = Federal	10/01 – 09/30
S = State	07/01 – 06/30
C = Calendar	01/01 – 12/31

Frequency Code Table	
Report Frequency	Reporting Data Period
Annually = A	Last two digits of year's data being reported
Semi-annually = S	01 or 02 for first or second data period being reported
Quarterly = Q	Two digits for quarter of data being reported (01, 02, 03, 04)
Monthly = M	Two-digit month of data being reported
Variable = V	Two-digit day of submission date (01-31)
Weekly = W	Two digits for week of data being reported (01, 02, 03, 04, 05)

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COUNTY CODE TABLE			
COUNTY NAME	COUNTY ID	AHCA AREA	DCF CIRCUIT
Alachua	01	03	08
Baker	02	04	08
Bay	03	02	14
Bradford	04	03	08
Brevard	05	07	18
Broward	06	10	17
Calhoun	07	02	14
Charlotte	08	08	20
Citrus	09	03	05
Clay	10	04	04
Collier	11	08	20
Columbia	12	03	03
Desoto	14	08	12
Dixie	15	03	03
Duval	16	04	04
Escambia	17	01	01
Flagler	18	04	07
Franklin	19	02	02
Gadsden	20	02	02
Gilchrist	21	03	08
Glades	22	08	20
Gulf	23	02	14
Hamilton	24	03	03
Hardee	25	06	10
Hendry	26	08	20
Hernando	27	03	05
Highlands	28	06	10
Hillsborough	29	06	13
Holmes	30	02	14
Indian River	31	09	19
Jackson	32	02	02
Jefferson	33	02	14
Lafayette	34	03	03
Lake	35	03	05
Lee	36	08	20
Leon	37	02	02

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COUNTY CODE TABLE (continued)			
COUNTY NAME	COUNTY ID	AHCA AREA	DCF CIRCUIT
Levy	38	03	08
Liberty	39	02	02
Madison	40	02	03
Manatee	41	06	12
Marion	42	03	05
Martin	43	09	19
Miami-Dade	13	11	11
Monroe	44	11	16
Nassau	45	04	04
Okaloosa	46	01	01
Okeechobee	47	09	19
Orange	48	07	09
Osceola	49	07	09
Palm Beach	50	09	15
Pasco	51	05	06
Pinellas	52	05	06
Polk	53	06	10
Putnam	54	03	07
Santa Rosa	57	01	01
Sarasota	58	08	12
Seminole	59	07	18
St. Johns	55	04	07
St. Lucie	56	09	19
Sumter	60	03	05
Suwannee	61	03	03
Taylor	62	02	03
Union	63	03	08
Volusia	64	04	07
Wakulla	65	02	02
Walton	66	01	01
Washington	67	02	14

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File Naming Convention Examples

Example: File Name **ABC201406KA130122 =**

ABC Managed Care Plan
2013 Cultural Competency Plan due June 1, 2014

- Managed Care Plan's three-character identifier = ABC
- Four-digit year in which report is due = 2014
- Two-digit month in which report is due = 06
- One-character identifier for the report's year type from the Report Year Type Table = K
- One-character identifier for report frequency from the Frequency Code Table = A
- Two digits indicating the specific data period being reported from the Frequency Code Table (Reporting Data Period) = 13 (Reporting Data Period 2013)
- Four-digit report code identifier for the Cultural Competency Plan = 0122

Example: File Name **ABC201304CQ040102 =**

ABC Managed Care Plan
1st Quarter 2013 Case Management File Audit Report due April 30, 2013

- Managed Care Plan's three-character identifier = ABC
- Four-digit year in which report is due = 2013
- Two-digit month in which report is due = 04
- One-character identifier for report's year type from the Report Year Type Table = C
- One-character identifier for report frequency from the Frequency Code Table = Q
- Two digits indicating the specific data period being reported from the Frequency Code Table (Reporting Data Period) = 01 (Reporting Data Period 1st Quarter ending 03/31/13)
- Four-digit report code identifier for the Case Management File Audit Report = 0102

Example: File Name **ABC201310CM130129.xls =**

ABC Managed Care Plan
September 2013 Missed Services Report due October 30, 2013

- Managed Care Plan's three-character identifier = ABC
- Four-digit year in which report is due = 2013
- Two-digit month in which report is due = 10

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- One-character identifier for the report's year type from the Report Year Type Table = C
- One-character identifier for report frequency from the Frequency Code Table = M
- Two digits indicating the specific data period being reported from the Frequency Code Table (Reporting Data Period) = 09 (September reporting period)
- Four-digit report code identifier for the Missed Services Report = 0129

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Section Two: Core Reports

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Chapter 3: Administrative Subcontractors and Affiliates Report

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

Capitated Managed Care Plan Contract Type

LTC Plan Type

- LTC HMO
- LTC Capitated PSN

Fee-for-Service PSN Contract Type

LTC Plan Type

- LTC FFS PSN

REPORT PURPOSE:

The purpose of this report is to provide a mechanism for Managed Care Plans to report ownership and financial information for all subcontractors¹ and affiliates² to which the Managed Care Plan has delegated any responsibility or service for the Medicaid product line. This is an informational reporting mechanism only. The inclusion of an entity on this report does not constitute Agency approval of the Managed Care Plan's subcontract or relationship with that entity. Entities already reported in the Provider Network File shall not be included on this report.

FREQUENCY & DUE DATES:

This report is due quarterly within 15 calendar days after the end of the reporting quarter.

SUBMISSION:

Using the file naming convention described in Chapter 2, the Managed Care Plan shall submit the following to the SMMC SFTP site:

- The Managed Care Plan's Administrative Subcontractors and Affiliates Report.
- A report attestation described in Chapter 2.

¹ For purposes of this report, "Subcontractor" means any person or entity with which the Managed Care Plan has contracted or delegated administrative functions, services or responsibilities for providing services under this Contract, excluding those persons or entities reported by the Managed Care Plan in the Provider Network File.

² For purposes of this report, "Affiliate" or "affiliated person" means: (1) Any person or entity who directly or indirectly manages, controls, or oversees the operation of the Managed Care Plan, regardless of whether such person or entity is a partner, shareholder, owner, officer, director, agent, or employee of the entity. (2) Any person or entity who has a financial relationship with the Managed Care Plan as defined by 42 CFR 438.320 (1), and/or, (3) An individual or entity who meets the definition of an affiliate as defined in 48 CFR 19.101.

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INSTRUCTIONS:

The Managed Care Plan shall submit the report using the Agency's template via the SMMC SFTP site to the plan-specific file folder in the following manner. To meet the requirement for report submission, all applicable fields must be completed by the Managed Care Plan for each business entity being reported unless instructions specify otherwise. If a field is not applicable, enter N/A. In this report, do not include entities already reported in the Provider Network File.

Header rows on the template are numbered above header titles. Drop-down selection boxes with pre-populated values and help boxes are located throughout the template. Use one line of entry for each subcontractor/affiliate. If the subcontractor/affiliate has more than one owner (see 13a through 13c), complete fields 1 through 12 for each owner. Template fields are as follows:

1. Managed Care Plan ID: Enter the Managed Care Plan's three-character identifier.
2. Managed Care Plan Name: Enter the name of the Managed Care Plan.
3. Managed Care Plan Medicaid Provider Number: Provide the primary (base seven-digit) Medicaid provider number of the Managed Care Plan including leading zeroes when applicable. Field length is seven digits. Leading zeroes will be applied to any entry that is less than seven digits.
4. Reporting Year: Select the Calendar Year being reported.
5. Reporting Quarter: Select the Quarter in the Calendar Year being reported.
6. Subcontractor/Affiliate Name: Enter the name of the Managed Care Plan's subcontractor or affiliate being reported. Entities already reported in the Provider Network File are not to be included on this report.
7. Business Entity Type: Select whether the entity being reported is a subcontractor of the Managed Care Plan, an affiliate of the Managed Care Plan, or both an affiliate and a subcontractor.
8. Tax I.D. (SSN/FEIN): Enter the tax identification number of the subcontractor or affiliate. Only nine numeric characters are allowed. Leading zeroes will be applied to any entry that is less than nine digits.
9. Correspondence Address: Enter the mailing or correspondence address of the subcontractor or affiliate being reported using the:
 - a. Street Address or P.O. Box
 - b. City
 - c. State – two character identifier
 - d. Zip Code – five digits
 - e. Country

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10. Subcontractor/Affiliate Physical Address:
 - a. Street Address
 - b. City
 - c. State – two character identifier
 - d. Zip Code – five digits
 - e. Country
11. Parent Company Name (if applicable):
 - a. If the subcontractor/affiliate being reported is a subsidiary, enter the name of the parent company.
 - b. State: Select the state where the parent company is located.
 - c. Country: Select the country where the parent company is located.
12. Service Type: Enter service type(s) subcontracted or delegated by the Managed Care Plan to the subcontractor/affiliate. Service type examples include but are not limited to member services, third-party administrator, claims processing, fulfillment vendor (printing and mailing), provider credentialing, provider contracting, and provider services. Separate each service type description using a semi-colon.
13. Subcontractor/Affiliate Ownership: If the subcontractor/affiliate has more than one owner, complete fields 1 through 12, along with 13a, 13b, and 13c, for each owner/organization name.
 - a. Last Name (or Organization Name): Enter the last name of the individual or the name of the organization having ownership of the subcontractor or affiliate. Enter one name or organization per line.
 - b. First Name: Enter the first name of the individual having ownership of the subcontractor or affiliate (if applicable). If not applicable, enter N/A. Enter one name per line.
 - c. Percent Ownership: Using a decimal point, enter the numerical value of the ownership percentage of the subcontractor/affiliate. Do not use the % character. NOTE: If the decimal point is not manually inserted, the system will automatically insert the decimal followed by two zeros.
14. Payment Methodology: Select the Managed Care Plan's payment method for the subcontractor/affiliate services from the drop-down box. Options are "Contingency Fee," "Capitation" (per member), "Cost Reimbursement," "Fixed per Unit Price" or "Other." If "Other" is selected, explain the payment methodology in field 14a.
 - a. Payment Methodology - Other: This is an open text field. Describe the Managed Care Plan's payment method for subcontractor or affiliate services when "other" is selected in field 14.
15. Subcontract Beginning Date: Select the mm/dd/yyyy of the beginning of the subcontract.
16. Subcontract End Date: Select the mm/dd/yyyy of the end of the subcontract.

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17. Downstream Delegation of Services: Select Yes or No, as appropriate, if the subcontractor or affiliate further subcontracts or delegates any services or functions under the Managed Care Plan's Medicaid contract obligation(s) to another entity.
18. Comments: This is an open text, narrative field, provided for other relevant information or comments regarding this report.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency-supplied template must be used as specified in the Report Guide. No alterations or duplication shall be made to the report template by Managed Care Plan. The Agency-supplied template to be used can be found on the Agency for Health Care Administration information web page at:

http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC/Report_Guides/Administrative_Subcontractors_and_Affiliates_Report.xls

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Chapter 4: Annual Fraud and Abuse Activity Report

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

Capitated Managed Care Plan Contract Type

LTC Plan Type

- LTC HMO
- LTC Capitated PSN

Fee-for-Service PSN Contract Type

LTC Plan Type

- LTC FFS PSN

REPORT PURPOSE:

The purpose of this report is to provide the Agency a summarized annual report on the Managed Care Plan's experience in implementing an anti-fraud plan and conducting or contracting for investigations of possible fraudulent or abusive acts for the prior State Fiscal Year (SFY).

Note: This report currently applies to the Medicaid SMMC LTC product line only. All dollar amounts are to be reported for any overpayment, fraud, or abuse acts.

As used in this report, the terms "overpayment," "fraud," and "abuse" are defined and as referenced in Attachment II, Core Contract Provisions, Section I, Definitions and Acronyms. The Contract definition for the term "abuse" is specified as "abuse (for program integrity functions)."

FREQUENCY & DUE DATES:

This report is due annually by September 1. If the due date falls on a weekend or holiday, the report is due on the following business day.

SUBMISSION:

The Managed Care Plan shall submit the following to the Agency's Office of the Inspector General, Bureau of Medicaid Program Integrity's MPI-MC SFTP site. Contact the Agency's MPI Business Manager (MPI Site Administrator) for access information via MPIBusiness.Manager@ahca.myflorida.com.

- The Managed Care Plan's MPI - Annual Fraud and Abuse Activity Report saved in XLS format, and submitted as an electronic file. The Managed Care Plan must use the file naming convention described in Chapter 2 with the following exceptions:

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- a. Add “_LTC” to the end of the Managed Care Plan three-character alpha identifier (for example, for an LTC plan named ABC, the plan identifier would be “ABC_LTC”), and
- b. For the report data period, indicate the last two digits of the state fiscal year ending the reporting period. For example, if the reporting period is for state fiscal year July 1, 2013 – June 30, 2014, the report data period would appear as 14. The following is a file name example:

Example: File Name **ABC_LTC201409SA140133 =**

ABC Managed Care Plan
2013 – 2014 Annual Fraud and Abuse Activity Report due September 1,
2014

- Managed Care Plan’s three-character identifier = ABC
 - Four-digit year in which report is due = 2014
 - Two-digit month in which report is due = 09
 - One-character identifier for the report’s year type from the Report Year Type Table = S
 - One-character identifier for report frequency from the Frequency Code Table = A
 - Two digits indicating the specific data period being reported from the Frequency Code Table (Reporting Data Period) = 14 (Reporting Data Period State Fiscal Year 2013 – 2014)
 - Four-digit report code identifier for the Annual Fraud and Abuse Activity Report= 0133
- A report attestation as described in Chapter 2. The certification (and delegation of authority if applicable – See Chapter 2) must be scanned and submitted electronically to the MPI SFTP site in PDF format with the certified data. The attestation must be named using the file naming convention described in Chapter 2 with the exception described above for the report file naming convention (adding “_LTC” to the end of the plan’s three-digit identifier, and indicating, for the report data period, the last two digits of the state fiscal year ending the reporting period). Upload this PDF file through the web-based application to MPI-MC SFTP site. The written delegation of authority for this report must be contemporaneous and renewed each calendar year.

INSTRUCTIONS:

The Managed Care Plan’s primary contact shall obtain access to the MPI-MC SFTP site through the Agency’s MPI Business Manager (or designated representative). The Managed Care Plan user shall implement Agency-approved FTP client software, such as Filezilla, or utilize the web-transfer client provided by AHCA. Security credentials (a single user ID and password) will be provided via encrypted email once the user’s

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registration is approved. Use the appropriate host name for the MPI-MC SFTP site: sftp.ahca.myflorida.com, port 2232. The plan is responsible for plan user security and shall maintain the user security access for plan staff. The MPI-MC SFTP site is limited to submitting and retrieving electronic file information within the plan-specific folder. The plan password is reissued by email only to the approved registered user, and will expire every 90 days in accordance with the Agency's security protocol. Password reset reminders and instructions will be sent to the registered user (account holder) seven days prior to expiration, and upon expiration. The Managed Care Plan shall successfully submit a test file within 10 calendar days after the password is issued and as requested by the Agency.

The registered user will be notified by email in the event of an account lock out due to multiple, incorrect password attempts. The primary account holder will be notified by email when the account has been locked. The account lockout will last for 30 minutes, and then it will be automatically cleared by the system. Users can have the block cleared immediately by contacting their AHCA MPI-MC Site Administrator (MPI Business Manager).

Entering the incorrect username (i.e., a username that does not exist) will cause the user's IP address to be blocked. For the IP address block to take place, the user must attempt to connect with the incorrect username more than five times in 60 seconds. This form of lockout must be cleared by AHCA's network staff. The external user must contact their AHCA Site Administrator (MPI Business Manager) for MPI reporting at MPIBusiness.Manager@ahca.myflorida.com to resolve this issue.

Termination of access is required in instances where there is a change of responsibilities or employee termination. A request to terminate a user's access must be submitted by the Managed Care Plan's primary contact and must include the user's full name, position title, and business email address. The Managed Care Plan must submit the request by email to MPIBusiness.Manager@ahca.myflorida.com.

The Managed Care Plan shall submit the MPI – Annual Fraud and Abuse Activity Report via the MPI-MC SFTP site to the plan-specific file folder in the following manner using the same format as the XLS template:

Note: ** = A drop down selection box with pre-populated values (selections). Header fields on the template are numbered and header titles are abbreviated (below each number). There are some help boxes located throughout the template.

1. AHCA Contract Number: Enter the alpha-numeric Contract Number, assigned by the Agency that appears on the Agency's contract with the Managed Care Plan.
2. Medicaid Contract Type**: Select Long-term Care for Long-term Care line entries.
3. State Fiscal Year**: Select the State Fiscal Year for the year being reported. Note: State Fiscal Years run from July 1 – June 30.

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4. Managed Care Plan Identifier: Provide the Managed Care Plan's three-alpha-character identifier.
5. Managed Care Plan Medicaid Provider Number: Provide the primary Medicaid provider number of the Managed Care Plan including leading zeroes when applicable. Only one line of entry is allowed. Field length is nine digits. Leading zeroes will be applied to any entry that is less than nine digits.
6. Total Overpayments Identified for Recovery: Report the total amount of all dollars identified as lost to overpayment, abuse, and fraud during the State Fiscal Year being reported. *This amount shall include the dollar amount being reported in 6a. and 7.* Report dollars and cents by entering numeric characters only. Do not input dollar signs (\$), decimals or commas; only numeric characters are allowed. The field is formatted to automatically input dollar signs and decimals. If no dollar losses attributable to overpayment, abuse or fraud were identified during the State Fiscal Year being reported, insert zero (0).
 - a. Total Overpayments Recovered: Of the total amount of overpayment identified for recovery, report the amount of total dollars recovered attributable to overpayment, abuse, and fraud during the State Fiscal Year being reported. Report the total dollar amount of recoveries attributable to overpayment, abuse, and fraud during the State Fiscal Year being reported. Report dollars and cents by entering numeric characters only. Do not input dollar signs (\$), decimals or commas; only numeric characters are allowed. The field is formatted to automatically input dollar signs and decimals. If no recoveries of losses attributable to overpayment, abuse or fraud occurred during the State Fiscal Year being reported, insert zero (0).
7. Total Dollars Identified as Lost to Fraud and Abuse: Of the total amount of overpayments identified for recovery, report the portion of total overpayments identified for recovery which were identified as being lost only to fraud and abuse during the State Fiscal Year being reported. *This amount shall include the dollar amount being reported in 7a.* Report the total dollar amount identified as lost to abuse and fraud during the State Fiscal Year being reported. Report dollars and cents by entering numeric characters only. Do not input dollar signs (\$), decimals or commas; only numeric characters are allowed. The field is formatted to automatically input dollar signs and decimals. If no dollar losses attributable to abuse and fraud were identified during the State Fiscal Year being reported, insert zero (0).
 - a. Total Dollars Lost to Fraud and Abuse That Were Recovered: Of the portion of dollars identified as being lost to fraud and abuse, report the amount of total dollar recovered attributable to being lost to fraud and abuse during the State Fiscal Year being reported. Report the total dollar amount of all recoveries of dollars lost to fraud and abuse made during the State Fiscal Year being reported. Report dollars and cents by entering numeric characters only. Do not input dollar

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signs (\$), decimals or commas; only numeric characters are allowed. The field is formatted to automatically input dollar signs and decimals. If no recoveries of losses attributable to abuse and fraud have occurred, during the State Fiscal Year being reported, insert zero (0).

8. Total Number of Referrals: Enter the total number of referrals made to the Agency's Office of the Inspector General, Bureau of Medicaid Program Integrity, during the State Fiscal Year being reported.
9. Narrative Field: A narrative field is provided for other relevant information or comments regarding this report.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency-supplied template must be used as specified in the Report Guide. No alterations or duplication shall be made to the report template by Managed Care Plan. The Agency-supplied template to be used can be found on the Agency for Health Care Administration information web page at:

http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC/Report_Guides/MPI_Annual_Fraud_and_Abuse_Activity_Report_LTC.xls

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Chapter 5: Audited Annual and Unaudited Quarterly Financial Reports

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

Capitated Managed Care Plan Contract Type

LTC Plan Type

- LTC HMO
- LTC Capitated PSN

Fee-for-Service PSN Contract Type

LTC Plan Type

- LTC FFS PSN

REPORT PURPOSE:

The purpose of this report is to provide the Agency with unaudited quarterly financial statements, an audited annual financial statement, an audited annual report and a letter of opinion from an independent auditor (certified public accountant unaffiliated with the Managed Care Plan).

FREQUENCY & DUE DATES:

Unaudited financial statements are due quarterly, within 45 calendar days after the end of each reported quarter.

Audited financial statement, audited annual report and the letter of opinion from an independent auditor are due annually, on or before April 1 following the end of each reported calendar year.

SUBMISSION:

The Managed Care Plan shall submit the following via a single, non-secure email to the Agency's Bureau of Managed Health Care (BMHC) mailbox at MMCFIN@ahca.myflorida.com:

- For the unaudited quarterly submissions:
 - a. The completed and accurate financial statement report template, which shall be submitted as an XLS file and named F***YYQ#.xls, where *** is the Managed Care Plan's three-character identifier from the Plan Identifier Table (see Chapter 2), YY are the last two digits of the calendar year being reported, and # is the one digit of the quarter being reported (i.e., ABC Managed Care Plan's submission for the 1st quarter of 2013 would be named "FABC13Q1.xls").
 - b. The jurat page (included in the financial statement report template), which shall also be submitted separately as a PDF file (with signatures) and named

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- F***YYQ#-jurat.pdf, where *** is the Managed Care Plan's three-character identifier, YY are the last two digits of the calendar year being reported, and # is the one digit of the quarter being reported. This jurat page must be signed only by the Managed Care Plan's CEO. **Delegate signatures will not be accepted.**
- c. A report attestation, as described in Chapter 2 for the completed and accurate financial statement report template, which shall be submitted with the certified data as a PDF file and named F***YYQ#-cert.pdf, where *** is the Managed Care Plan's three-character identifier, YY are the last two digits of the calendar year being reported, and # is the one digit of the quarter being reported. This attestation must be signed by the Managed Care Plan's CEO, chief financial officer (CFO), or a direct report with written delegated authority certifying that all data and documents submitted are accurate, truthful, and complete. Such delegations of authority must be attached to the submitted signed attestation to certify report.
- For the audited annual submissions:
- a. The completed and accurate financial statement report template showing any corrections made by the independent auditor, which shall be submitted as an XLS file and named AF***YYYY.xls, where *** is the Managed Care Plan's three-character identifier, and YYYY are the four digits of the calendar year being reported.
 - b. The jurat page (included in the financial statement report template), which shall be submitted as a PDF file and named AF***YYYY-jurat.pdf, where *** is the Managed Care Plan's three-character identifier, and YYYY are the four digits of the calendar year being reported. This jurat page must be signed only by the Managed Care Plan's CEO. **Delegate signatures will not be accepted.**
 - c. A report attestation, as described in Chapter 2 for the completed and accurate financial statement report template, which shall be submitted with the certified data as a PDF file and named AF***YYYY-cert.pdf, where *** is the Managed Care Plan's three-character identifier, and YYYY are the four digits of the calendar year being reported. This attestation must be signed by the Managed Care Plan's CEO, CFO, or a direct report with written delegated authority certifying that all data and documents submitted are accurate, truthful, and complete. Such delegations of authority must be attached to the submitted signed attestation to certify report.
 - d. The independent auditor's financial report and letter of opinion, which shall be submitted as a PDF file and named AFO***YYYY.pdf, where *** is the Managed Care Plan's three-character identifier, and YYYY are the four digits of the calendar year being reported.

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INSTRUCTIONS:

1. The Managed Care Plan shall complete the financial reporting submission requirements using the Excel file template, provided at the Agency's website specified in the report template section, to report the following sets of financial data:
 - Balance Sheet;
 - Statement of Revenues and Expenses;
 - Statement of Cash Flow; and
 - Footnotes.
2. It is the responsibility of the Managed Care Plan to use the most current financial statement report template supplied by the Agency. The Agency will provide the most recent template within the first quarter of each reporting year.
3. The Managed Care Plan must file a combined financial statement report for its unaudited quarterly and audited annual statements. These combined financial statement(s) should be submitted and emailed as a single report.
4. The Managed Care Plan shall use generally accepted accounting principles (GAAP) in preparing all financial statements; however, if the Managed Care Plan is also required to file with the State of Florida Office of Insurance Regulation, then the annual financial statement and the annual independent auditor's financial report may be submitted using statutory accounting.
5. The Managed Care Plan shall submit financial statements that are specific to the operations of the Managed Care Plan rather than to a parent or umbrella organization.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency-supplied template must be used as specified in the Report Guide. No alterations or duplication shall be made to the report template by Managed Care Plan. The Agency-supplied template to be used can be found on the Agency for Health Care Administration information web page at:

http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC/Report_Guides/Audited_Annual_Unaudited_Quarterly_Financial_Reports_LTC.xls

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The Agency's template consists of the following:

- A financial workbook to report financial data, which includes an instructions page, and
- A jurat page (in the financial workbook).

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Chapter 6: Claims Aging Report & Supplemental Filing Report

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

Capitated Managed Care Plan Contract Type

LTC Plan Type

- LTC HMO
- LTC Capitated PSN

Fee-for-Service PSN Contract Type

LTC Plan Type

- LTC FFS PSN

REPORT PURPOSE:

The purpose of this report is to provide the Agency with assurance that claims are processed and payment systems comply with the federal and State requirements, whichever is more stringent.

FREQUENCY & DUE DATES:

This report is due quarterly, within 45 calendar days after the end of the reported quarter.

For capitated Managed Care Plans, the optional Supplemental Report is due within 105 calendar days after the end of the reported quarter.

SUBMISSION:

Using the file naming convention described in Chapter 2, the Managed Care Plan shall submit the following to the SMMC SFTP site:

- For the quarterly submissions:
 - a. The completed claims aging report template, which shall be submitted as an XLS file and named using the file naming convention as described in Chapter 2.
 - b. A report attestation, as described in Chapter 2 for the completed claims aging report template, which shall be submitted with the certified data as a PDF file. This attestation must be signed by the Managed Care Plan's CEO, CFO or a direct report with written delegated authority certifying that all data and documents submitted are accurate, truthful, and complete. Such delegations of authority must be attached to the submitted signed attestation to certify the report.

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- For the optional supplemental submissions (capitated Managed Care Plans only):
 - a. The completed claims aging supplemental filing report template, which shall be submitted as an XLS file and named using the file naming convention as described in Chapter 2.
 - b. The attestation (see Chapter 2) for the completed claims aging supplemental filing report template, which shall be submitted with the certified data as a PDF file and named using the file naming convention as described in Chapter 2. This attestation must be signed by the Managed Care Plan's chief executive officer (CEO), chief financial officer (CFO) or a direct report with written delegated authority certifying that all data and documents submitted are accurate, truthful, and complete. Such delegations of authority must be attached to the submitted signed attestation to certify the report.

INSTRUCTIONS:

1. The Managed Care Plan shall complete the quarterly Claims Aging Report(s) and, if applicable, Claims Aging Supplemental Filing Report(s), using the appropriate report template (specific to Managed Care Plan type) provided on the Agency Website (see the "Report Template" section of this chapter).
2. Claims data must be Medicaid only.
3. Claims data must not be run for this report until at least 31 calendar days after the end of the report quarter but before the due date for filing (45 calendar days after the reported quarter).
4. Claims data reported is for clean claims received, paid and denied during the reporting period (see template).
5. Fee-for-service Managed Care Plans that receive capitation from the Agency for covered services must report such claims as specified for capitated claims reporting in the reporting template for FFS LTC PSNs.
6. If the capitated Managed Care Plan chooses to file a Claims Aging Supplemental Filing Report, it may report claims received during the reported quarter and processed within 90 calendar days of receipt. The supplemental reporting is voluntary on the part of the capitated Managed Care Plan.

VARIATIONS BY MANAGED CARE PLAN TYPE:

Templates and reporting requirements are unique to specific Managed Care Plan types (fee-for-service LTC Managed Care Plans have one template; capitated LTC Managed Care Plans have another – see the "Report Templates" section of this chapter).

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REPORT TEMPLATE:

The Agency-supplied template must be used as specified in the Report Guide. No alterations or duplication shall be made to the report template by Managed Care Plan. The Agency-supplied claims aging report template for capitated Managed Care Plans (for the required quarterly and optional supplemental submission) to be used can be found at:

http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC/Report_Guides/Claims_Aging_Report_Supplemental_Filing_Capitated_LTC.xls

The Agency-supplied claims aging template for fee-for-service LTC Managed Care Plans to be used can be found at:

http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC/Report_Guides/Claims_Aging_Report_FFS_LTC.xls

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Chapter 7: Community Outreach Health Fairs/Public Events Notification

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

Capitated Managed Care Plan Contract Type

LTC Plan Type

- LTC HMO
- LTC Capitated PSN

Fee-for-Service PSN Contract Type

LTC Plan Type

- LTC FFS PSN

REPORT PURPOSE:

The purpose of this report is to provide written notice to the Agency of the Managed Care Plan's intent to attend and provide community outreach materials at health fairs/public events.

FREQUENCY & DUE DATES:

This report is due monthly, no later than the 20th calendar day of the month prior to the event month.

Amendments to the report are due no later than two weeks prior to the event (variable).

SUBMISSION:

Using the file naming convention described in Chapter 2, the Managed Care Plan shall submit a community outreach health fairs/public events notification report to the SMMC SFTP site:

- An outreach/public event report using the Agency-supplied template. **The month used in the naming convention will represent the month the event will occur.**
- An amendment to a reported event when there is a change in time, location, date or cancellation of the event. **The month used in the naming convention will be the same month the event was originally scheduled to occur.**
- A report attestation as described in Chapter 2.

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INSTRUCTIONS:

1. The Managed Care Plan shall create the Community Outreach Health Fairs/Public Events Notification in the format and layout specified in the report template.
2. The Managed Care Plan shall submit all events on the same template. If no events are planned in any month, the Managed Care Plan must file the template indicating “none” on the first line of the template.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency-supplied template must be used as specified in the Report Guide. No alterations or duplication shall be made to the report template by Managed Care Plan. The Agency-supplied template to be used can be found on the Agency for Health Care Administration information web page at:

http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC/Report_Guides/Community_Outreach_Health_Fairs_Public_Events_Notification_LTC.xls

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Chapter 8: Community Outreach Representative Report

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

Capitated Managed Care Plan Contract Type

LTC Plan Type

- LTC HMO
- LTC Capitated PSN

Fee-for-Service PSN Contract Type

LTC Plan Type

- LTC FFS PSN

REPORT PURPOSE:

The purpose of this report is to ensure Managed Care Plans register each community outreach representative with the Agency as required in Attachment II, Section IV, of the model Managed Care Plan Contract provisions.

FREQUENCY & DUE DATES:

This report is due quarterly, within 45 calendar days after the end of the reporting quarter.

This report is also due two weeks prior to any outreach activities to be performed by the representative (variable).

SUBMISSION:

Using the file naming convention described in Chapter 2, the Managed Care Plan shall submit the Community Outreach Representative Registration Template to the SMMC SFTP site:

- A file in the template supplied within this chapter.
- The Managed Care Plan shall submit changes to the community outreach representative's initial registration to the Agency, using the same Agency-supplied template, immediately upon occurrence.

INSTRUCTIONS:

1. The Community Outreach Representative Registration Template is an Excel workbook consisting of three worksheets:
 - a. Instructions for the completion of the template.
 - b. Jurat – Managed Care Plan information.

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- c. Representative Activity – Community outreach representative information including any change in status.
2. In the event that there are no representative activities to report for a quarter, a blank report must still be submitted along with an attestation.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency-supplied template must be used as specified in the Report Guide. No alterations or duplication shall be made to the report template by Managed Care Plan. The Agency-supplied template to be used can be found on the Agency for Health Care Administration information web page at:

http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC/Report_Guides/Community_Outreach_Representative_Report_LTC.xls

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Chapter 9: Critical Incident Report

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

Capitated Managed Care Plan Contract Type

LTC Plan Type

- LTC HMO
- LTC Capitated PSN

Fee-for-Service PSN Contract Type

LTC Plan Type

- LTC FFS PSN

REPORT PURPOSE:

The purpose of this report is to monitor all Managed Care Plans' critical and adverse incident reporting and management system for critical incidents that negatively impact the health, safety or welfare of enrollees. This report includes critical and adverse incidents that occur in a home and community-based services (HCBS) long-term care delivery setting, including: community-based residential alternatives; other HCBS provider sites; and an enrollee's home, if the incident is related to the provision of covered HCBS.

FREQUENCY & DUE DATES:

This report is due immediately upon occurrence and **no later than** twenty-four (24) hours after detection or notification.

SUBMISSION:

Using the file naming convention described in Chapter 2, the Managed Care Plan shall submit the following via secure, encrypted email to the Agency's LTC Managed Care Plan Contract manager:

- Critical Incident Report using the template provided.
- A report attestation as described in Chapter 2.

INSTRUCTIONS:

The Managed Care Plan shall report the following to the Agency in accordance with the format set forth in the Critical Incident Report Template:

- Enrollee's full name (first, last)
- Enrollee's Medicaid ID
- Reporting date (mm/dd/yyyy)
- Date of incident (mm/dd/yyyy)
- Address of incident

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- County name
- Information regarding whether or not the incident occurred in a facility
- Name of facility (if applicable)
- Incident details
- Outcome of the incident, including current status of the enrollee
- Date resolved (mm/dd/yyyy)

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE

The Agency-supplied template must be used as specified in the Report Guide. No alterations or duplication shall be made to the report template by Managed Care Plan. The Agency-supplied template to be used can be found on the Agency for Health Care Administration information web page at:

http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC/Report_Guides/Critical_Incident_Report.xls

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Chapter 10: Critical Incident Summary Report

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

Capitated Managed Care Plan Contract Type

LTC Plan Type

- LTC HMO
- LTC Capitated PSN

Fee-for-Service PSN Contract Type

LTC Plan Type

- LTC FFS PSN

REPORT PURPOSE:

The purpose of this report is to monitor all Managed Care Plans' critical and adverse incident reporting and management system for critical incidents that negatively impact the health, safety or welfare of enrollees. This report includes critical and adverse incidents that occur in a home and community-based services (HCBS) long-term care delivery setting, including: community-based residential alternatives, other HCBS provider sites, and an enrollee's home, if the incident is related to the provision of covered HCBS.

FREQUENCY & DUE DATES:

This report is due monthly, by the 15th calendar day of the month following the reporting month and rolled up for quarter and year.

SUBMISSION:

Using the file naming convention described in Chapter 2, the Managed Care Plan shall submit the following to the SMMC SFTP site:

- Critical Incident Summary Report using the template provided.
- A report attestation as described in Chapter 2.

INSTRUCTIONS:

1. The Managed Care Plan shall create the Critical Incident Summary Report in the format and layout specified in the report template.
2. For the reporting quarter, the report shall include but not be limited to:
 - Enrollee's full name
 - Enrollee's Medicaid ID
 - Reporting date
 - Date of incident

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- Address of incident
- Name of facility (if applicable)
- Incident details
- Outcome of the incident, including current status of the enrollee
- Date resolved

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE

The Agency-supplied template must be used as specified in the Report Guide. No alterations or duplication shall be made to the report template by Managed Care Plan. The Agency-supplied template to be used can be found on the Agency for Health Care Administration information web page at:

http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC/Report_Guides/Critical_Incident_Summary_Report.xls

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Chapter 11: Provider Complaint Report

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

Capitated Managed Care Plan Contract Type

LTC Plan Type

- LTC HMO
- LTC Capitated PSN

Fee-for-Service PSN Contract Type

LTC Plan Type

- LTC FFS PSN

REPORT PURPOSE:

The purpose of this report is to assist the Agency and DOEA in monitoring the Managed Care Plan's complaint system. This is the system that permits a provider to dispute the Managed Care Plan's policies, procedures, or any aspect of a Managed Care Plan's administrative functions, including proposed actions, claims, billing disputes, and service authorizations. This report will detail the nature of the complaint, timeline of the complaint, as well as the resolution.

FREQUENCY & DUE DATES:

This report is due monthly, within 15 calendar days after the end of the reporting month.

SUBMISSION:

Using the file naming convention described in Chapter 2, the Managed Care Plan shall submit the following to the SMMC SFTP site:

- The completed Provider Complaint Report template, which shall be submitted as an XLS file.
- A report attestation, as described in Chapter 2 for the completed Provider Complaint Report template, which shall be submitted with the certified data as a PDF file.

INSTRUCTIONS:

1. The Managed Care Plan shall complete the Provider Complaint Report using the appropriate report template provided on the Agency Website.
2. The Managed Care Plan shall only use the reasons as permissible via the drop down boxes in the template for the nature of the complaint and description of the complaint disposition.

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3. The Managed Care Plan shall enter the dates for when the complaint was received and the disposition reached as mm/dd.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency-supplied template must be used as specified in the Report Guide. No alterations or duplication shall be made to the report template by Managed Care Plan. The Agency-supplied template to be used can be found on the Agency for Health Care Administration information web page at:

http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC/Report_Guides/Provider_Complaint_Report.xls

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Chapter 12: Provider Network File

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

Capitated Managed Care Plan Contract Type

Fee-for-Service PSN Contract Type

LTC Plan Type

- LTC HMO
- LTC Capitated PSN

LTC Plan Type

- LTC FFS PSN

REPORT PURPOSE:

The purpose of this report is to supply the Agency and its agents with up-to-date provider network information. This report serves dual purposes. The Agency uses the file to monitor the Managed Care Plan’s compliance with required provider network composition and provider-to-member ratios and for other uses deemed pertinent.

Updated provider network information is available to the Choice Counseling/Enrollment Broker. The Choice Counseling/Enrollment Broker loads this information into their system(s) to assist in voluntary plan enrollments.

FREQUENCY & DUE DATES:

This report, a full file refresh, is due weekly each Thursday by 5 p.m. EST.

SUBMISSION:

1. The Managed Care Plan shall submit the following files with the specified file naming conventions to the Agency’s choice counseling vendor’s SFTP site server.
 - Provider/Group/Hospital (PG)
 - Service Location (SL)
 - End of Transmission (EN)

Position	Format	Description
1-2	@(2)	PG = Provider / Group File
		SL = Service Location File
		EN = End of Transmission File
3-5	@(3)	The three letter code for the health plan submitting the file.
6-13	D(8)	The date of the file submission in YYYYMMDD format.
14-23	@(9)	Files submitted by plans should have a .dat extension. Files created by AHS in response to submissions will have a .response extension.

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Choice counseling vendor SFTP site:

URL: [fftp.automated-health.com](ftp://fftp.automated-health.com)

Connection Type: SFTP (SSH connection – a pop up will ask you to trust a key certificate – once you trust the certificate, the connection will be established)

IP address: 206.17.164.205 (only if required for firewall rules, everyone should use the URL)

Port: 22

2. All Managed Care Plans shall submit the following to the Agency via the SMMC SFTP site:
 - A signed attestation specifically addressing the accuracy and completeness of the Provider Network File submission, with the file name *****_PROVYYYYMMAttestation.pdf** (where ******* represents the Managed Care Plan's three character approved abbreviation, and **YYYYMM** represents the four-digit year and two-digit month of submission).

INSTRUCTIONS:

1. The Managed Care Plan shall create the Provider Network Files in the format and layout described in the Provider Network Verification File Specification document located at:

http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC/Report_Guides/PNV_File_Specification_ver1_1_06-18-2013.pdf
2. The Managed Care Plan must ensure that this is an electronic representation of the plan's network of contracted providers, not a listing of entities for whom claims have been paid.
3. Plans needing technical assistance for submitting Provider Network Files to, or retrieving Provider Network Response Files from, the **Choice Counseling vendor's** SFTP directory should contact the following helpdesk for assistance: AHSFL-Helpdesk@automated-health.com. For more immediate concerns regarding the submission of provider network files, plans may contact 412-367-3030 ext 2900.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

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REPORT TEMPLATE:

The Agency-supplied template must be used as specified in the Provider Network Verification File Specification document. No alterations or duplication shall be made to the report template by Managed Care Plan. The Agency-supplied Provider Network Verification File Specification provides detailed and specific information regarding Provider Network File and Provider Network Response File, and can be found on the Agency's web page at:

http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC/Report_Guides/PNV_File_Specification_ver1_1_06-18-2013.pdf

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Chapter 13: Provider Termination and New Provider Notification Report

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

Capitated Managed Care Plan Contract Type

LTC Plan Type

- LTC HMO
- LTC Capitated PSN

Fee-for-Service PSN Contract Type

LTC Plan Type

- LTC FFS PSN

REPORT PURPOSE:

The purpose of this report is to provide the Agency with notice in the event of a suspension, termination, or withdrawal of providers from participation in the Managed Care Plan's network; to provide the Agency with notice of new providers; and to provide documentation that the Managed Care Plan has performed enrollee notification in accordance with the provisions of the Managed Care Plan contract.

FREQUENCY & DUE DATES:

This report is due weekly, each Wednesday by 5 p.m. EST.

SUBMISSION:

Using the file naming convention described in Chapter 2, the Managed Care Plan shall submit the following to the SMMC SFTP site:

- A completed Provider Termination and New Provider Notification Report.
- A report attestation as described in Chapter 2.

INSTRUCTIONS:

1. The Managed Care Plan shall submit provider terminations and new/replacement providers for the prior reporting week using the Agency-supplied template. This submission must occur even when no provider terminations, suspensions, withdrawals, or new provider contracts occurred. The Managed Care Plan shall indicate "none" in the first line of the report if there are no such changes.
2. The Managed Care Plan shall report provider terminations using the "Medical Provider Term" tab.

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3. The Managed Care Plan shall report new/replacement providers using the “New Provider Information” tab.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency-supplied template must be used as specified in the Report Guide. No alterations or duplication shall be made to the report template by Managed Care Plan. The Agency-supplied template to be used can be found on the Agency for Health Care Administration information web page at:

http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC/Report_Guides/Provider_Termination_New_Provider_Notification_Report_LTC_09-30-2013.xls

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Chapter 14: Quarterly Fraud and Abuse Activity Report

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

Capitated Managed Care Plan Contract Type

LTC Plan Type

- LTC HMO
- LTC Capitated PSN

Fee-for-Service PSN Contract Type

LTC Plan Type

- LTC FFS PSN

REPORT PURPOSE:

The purpose of this report is to provide the Agency's Office of the Inspector General, Bureau of Medicaid Program Integrity (MPI), with a quarterly ongoing comprehensive fraud and abuse prevention activity report from the Managed Care Plan regarding their investigative, preventive, and detective activity efforts. This report allows the Managed Care Plan to demonstrate its due diligence for fraud and abuse compliance, including utilization control; to safeguard against unnecessary or inappropriate use of Medicaid services, excess payments, and underutilization; assess quality, and take necessary corrective action to ensure program effectiveness. This report also allows the Agency to track and trend data across all Managed Care Plans, including potential for aggregate feedback. This report is implemented as an adjunct tool in statewide surveillance for managed care fraud and abuse. This report is a supplemental comprehensive summary regarding the quarterly status, progression, and outcome of the Managed Care Plan's previously reported referrals of suspected/confirmed fraud and abuse.

Note: *This summary report does not replace the Managed Care Plan's requirement to report all suspected/confirmed fraud and abuse within 15 calendar days of detection to Medicaid Program Integrity (as per contractual provisions for using the online complaint form) through:*

https://apps.ahca.myflorida.com/InspectorGeneral/fraud_complaintform.aspx.

See also: *MPI – Suspected/Confirmed Fraud and Abuse Report Guide chapter.*

FREQUENCY & DUE DATES:

This report is due quarterly, within 15 calendar days after the end of the quarter being reported.

SUBMISSION:

To comply with the MPI - Quarterly Fraud and Abuse Activity Report (QFAAR) requirements, the Managed Care Plan shall submit the following:

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- The web-based QFAAR report to the Agency Office of the Inspector General, Bureau of Medicaid Program Integrity (MPI) via the web-based application site.
- A report attestation; the attestation shall be named MPI_QFAAR***_^^yyQ*-cert.pdf (replacing *** with the Managed Care Plan's unique alphabetic three character plan identifier, replacing ^^ with "LTC" for Long-term Care Plans, replacing yy with the year, and replacing * with the number of the quarter being reported). The report attestation must accompany each report submission. If the report attestation is not signed by the CEO or CFO, a written delegation of authority signed by the CEO or CFO for the report attestation signatory must accompany the submission each time the report is submitted. The delegated signatory must be a direct report to the CEO or CFO. If delegation is required, then the signed delegation document must be scanned, combined with the report attestation as one PDF file and uploaded through the web-based application site. The written delegation of authority for this report must be contemporaneous and renewed each calendar year.

INSTRUCTIONS:

The Managed Care Plan shall perform the following:

1. Obtain access to MPI's web-based application QFAAR site by browsing to the URL and clicking on the "New Users Register Here" link.
2. Complete the online user registration form (See Item 3. below for details) and click "submit."
3. Follow the directions to create a new user account. Using the drop-down selection, select the applicable Managed Care Plan name with "(Long Term Care)" following the name. Complete the online registration form and click "submit." After clicking the Submit button, if the user registered successfully, the user will be directed to the registration results page. The user will be required to print out the user agreement form. The user should read and complete the User Account Agreement form and sign the acknowledgement for the terms of the User Account Agreement. Managed Care Plan management approval must be obtained by signature of the Managed Care Plan's primary contact on the form. The Managed Care Plan primary contact's signature on the user agreement is sufficient to request access. Mail or fax the completed form using the information listed on the form. When access is approved by Agency MPI staff, an email will be generated to the user applicant, notifying the user of password activation or denial. The system allows for password changes by the approved user, but only with inserting the approved user's correct user ID. If the approved user cannot remember their correct user ID, the user must re-register with a new user ID.

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4. The web-based application allows the user to reset his/her own password as long as the user is able to use his/her user name. If the user name is forgotten, the user must reapply for access approval completing a new user agreement and select a name other than the prior user name.
5. **The Managed Care Plan's primary contact must notify the Agency to request deactivation (termination of access/request to remove a user) of a Managed Care Plan staff member's password, and to block access of said staff member to the web-based QFAAR application. Deactivation is required in the instances of change of responsibilities or employee termination.**
6. Termination of access is required in the instances of change of responsibilities or employee termination. A request to terminate a user's access must be submitted by the Managed Care Plan's primary contact and must also include the User's Full Name, Position Title, and Business Email Address. This request must be submitted by email to qfaar@ahca.myflorida.com.
7. The Managed Care Plan shall submit the MPI - Quarterly Fraud and Abuse Activity Report via MPI's web-based application. The Managed Care Plan shall first select its Managed Care Plan name with "(Long Term Care)" following, then select "Long Term Care" in the Medicaid Contract Type drop-down box. Records may be entered for the current quarter when the following conditions have been met:
 - a. Records from all previous quarters have been submitted, and
 - b. It is the 16th of the month or later for the current quarter.

Note: *On the web-based application, if "other" is selected for any data element, a narrative box will open. Input information in narrative box to describe or define what is meant by "other." Detailed instructions are available through the web-based application.*

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency's web-based application must be used as specified in the Report Guide. No alterations or duplication shall be made by Managed Care Plan to the report resulting from the Agency's web-based application. This application can be found at:

<https://apps.ahca.myflorida.com/QFAAR/login.aspx>

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Chapter 15: Suspected/Confirmed Fraud and Abuse Reporting

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

Capitated Managed Care Plan Contract Type

LTC Plan Type

- LTC HMO
- LTC Capitated PSN

Fee-for-Service PSN Contract Type

LTC Plan Type

- LTC FFS PSN

REPORT PURPOSE:

The purpose of this report is for Managed Care Plans to report all suspected or confirmed fraud and abuse under state and/or federal law relative to the Managed Care Plan contract and/or Florida Medicaid. Failure to report instances of suspected or confirmed fraud and abuse is a violation of law and subject to the penalties provided by law. Notwithstanding any other provision of law, failure to comply with these reporting requirements will be subject to sanctions.

FREQUENCY & DUE DATES:

This report is due within 15 calendar days of detection.

SUBMISSION:

The Managed Care Plan shall complete and submit the following Agency electronic data entry complaint form online to the Agency's Office of the Inspector General, Bureau of Medicaid Program Integrity (MPI):

- a. Agency online electronic data entry complaint form found at:

https://apps.ahca.myflorida.com/InspectorGeneral/fraud_complaintform.aspx

INSTRUCTIONS:

Report suspected or confirmed fraud and abuse relative to the Managed Care Plan's contract and Florida Medicaid.

1. The narrative box of the complaint form is required to be completed by describing the suspected fraudulent or abusive activities (including background, persons involved, events, dates, and locations). Be sure to include the who, what, when, where, why and how of the situation. If additional information/documents are being submitted via MPI's SFTP site, indicate and identify the submission in the narrative box of the online complaint form.

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2. All suspected or confirmed instances of provider fraud and abuse under state and/or federal law is to be reported to MPI within 15 calendar days of detection by filing the online report. The report shall contain at a minimum:
 - a. The date reported (“Date reported” is the date the online report is submitted to MPI);
 - b. The name of the Managed Care Plan reporting;
 - c. The Managed Care Plan’s Florida Medicaid provider number;
 - d. The name of the provider;
 - e. The provider’s Florida Medicaid provider number; if the provider is not enrolled as Medicaid provider, state this information in narrative field;
 - f. The provider’s National Provider Identifier (NPI) number;
 - g. The provider type;
 - h. The provider’s tax identification number;
 - i. A description of the acts allegedly involving suspected fraud or abuse:
 - (1) Source of complaint/detection tool utilized;
 - (2) Nature of complaint;
 - (3) If applicable, case closed due to:
 - (a) Corrective action completed by provider;
 - (b) Provider voluntarily left network;
 - (c) Provider involuntarily terminated by Managed Care Plan;
 - (d) Other (specify);
 - j. Potential overpayment identified;
 - k. If known, actual overpayment identified;
 - l. If applicable, overpayment collected or recouped from provider by Managed Care Plan.
3. Reporting suspected or confirmed **enrollee** fraud and abuse:

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- a. All suspected or confirmed instances of enrollee fraud and abuse under state and/or federal law is to be reported to MPI within 15 calendar days of detection by filing the online report. The report shall contain, at a minimum:
 - (1) The date reported (“Date reported” is the date the online report is submitted to MPI);
 - (2) The name of the Managed Care Plan reporting;
 - (3) The Managed Care Plan’s Florida Medicaid provider number;
 - (4) The name of the enrollee;
 - (5) The enrollee’s Managed Care Plan identification number;
 - (6) The enrollee’s Florida Medicaid identification number;
 - (7) A description of the acts allegedly involving suspected fraud or abuse:
 - (a) Source of complaint/detection tool utilized;
 - (b) Nature of complaint;
 - (c) Potential amount of ineligible payment identified.
4. Reporting all suspected or confirmed instances of internal fraud and abuse relating to the provision of and payment for Medicaid services including, but not limited to fraud and abuse acts related to the Managed Care Plan contract and/or Florida Medicaid that is other than provider and enrollee fraud and abuse (e.g. internal to the Managed Care Plan – Managed Care Plan employees/management, subcontractors, vendors, delegated entities):
5. The online report shall contain, at a minimum:
 - a. The date reported (“date reported” is the date the online report is submitted to MPI);
 - b. The name of the Managed Care Plan reporting;
 - c. The Managed Care Plan’s Florida Medicaid provider number;
 - d. The name of the individual or entity;
 - e. The entity’s tax identification number;
 - f. A description of the acts allegedly involving suspected fraud or abuse:
 - (1) Source of complaint/detection tool utilized;

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- (2) Nature of complaint (who, what, when, where, why, how);
 - (3) If applicable, case closed due to:
 - (a) Corrective action completed by provider;
 - (b) Provider voluntarily left network;
 - (c) Provider involuntarily terminated by Managed Care Plan;
 - (d) Other (specify);
 - g. Potential exposure/loss identified;
 - h. If known, actual exposure/loss identified;
 - i. If applicable, exposure/loss collected or recouped from individual or entity by the Managed Care Plan.
6. The Managed Care Plan may submit supplemental information via MPI's SFTP site. Reporting via the SFTP site is not a substitute for using the required online Medicaid Fraud and Abuse Complaint Form.
7. The Managed Care Plan's primary contact shall obtain access to MPI-MC SFTP site through the Agency's MPI Business Manager (or designated representative) to upload electronic supplemental documentation. The Managed Care Plan user shall implement Agency-approved FTP client software, such as Filezilla, or utilize the web-transfer client provided by AHCA. Security credentials (a single user ID and password) will be provided via encrypted email once the user's registration is approved. Use the appropriate host name for the MPI-MC SFTP site: <sftp.ahca.myflorida.com>, port 2232. The plan is responsible for plan user security and shall maintain the user security access for plan staff. The MPI-MC SFTP site is limited to submitting and retrieving electronic file information within the plan-specific folder. The plan password reissued by email only to the approved registered user, and will expire every 90 days in accordance with AHCA security protocol. Password reset reminders and instructions will be sent to the registered user (account holder) seven days prior to expiration, and upon expiration. The Managed Care Plan shall successfully submit a test file within 10 calendar days after the password is issued and as requested by the Agency.
8. The registered user will be notified by email in the event of an account lock out due to multiple, incorrect password attempts. The primary account holder will be notified by email when the account has been locked. The account lockout will last for 30 minutes, and then it will be automatically cleared by the system. Users can have the block cleared immediately by contacting their AHCA MPI-MC Site Administrator (MPI Business Manager).

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9. Entering the incorrect username (i.e. a username that does not exist) will cause the user's IP address to be blocked. For the IP address block to take place, the user must attempt to connect with the incorrect username more than five times in 60 seconds. This form of lockout must be cleared by AHCA's network staff. The external user must contact their AHCA Site Administrator (MPI Business Manager) for MPI reporting at MPIBusiness.Manager@ahca.myflorida.com to resolve this issue.
10. Termination of access is required in instances where there is a change of responsibilities or employee termination. A request to terminate a user's access must be submitted by the Managed Care Plan's primary contact and must include the user's full name, position title, and business email address. The Managed Care Plan must submit the request by email to MPIBusiness.Manager@ahca.myflorida.com.
11. Any additional supporting documentation must be HIPAA-compliant and may be submitted to MPI-MC SFTP site or by mail to:

AHCA Administrator, Intake Unit
Medicaid Program Integrity
Agency for Health Care Administration
2727 Mahan Drive, MS #6, Tallahassee, FL 32308
Phone: 850-412-4600

Agency Consumer Complaint Call Center: 1-888-419-3456

12. If reporting a provider that does not have a Medicaid provider number (enrolled or registered), the Managed Care Plan shall include provider identifying information in narrative form.
13. An acknowledgement from the intake unit at MPI is generated for all online reporting received.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

The MPI's general website is located at:

http://ahca.myflorida.com/Executive/Inspector_General/medicaid.shtml

The complaint report form is available online at:

https://apps.ahca.myflorida.com/InspectorGeneral/fraud_complaintform.aspx

Section Three: Long-term Care Reports

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Chapter 16: Case Management File Audit Report

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

Capitated Managed Care Plan Contract Type

LTC Plan Type

- LTC HMO
- LTC Capitated PSN

Fee-for-Service PSN Contract Type

LTC Plan Type

- LTC FFS PSN

REPORT PURPOSE:

The purpose of this report is to ensure that a system of internal monitoring of the case management program is in place and that enrollees are receiving quality care.

FREQUENCY & DUE DATES:

This report is due quarterly, within 30 calendar days after the end of the reporting quarter.

SUBMISSION:

Using the file naming convention described in Chapter 2, the Managed Care Plan shall submit the following to the SMMC SFTP site:

- Case Management File Audit Report using the template provided.
- A report attestation as described in Chapter 2.

INSTRUCTIONS:

The Managed Care Plan shall create the Case Management File Audit Report in the format and layout specified in the report template.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

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REPORT TEMPLATE:

The Agency-supplied template must be used as specified in the Report Guide. No alterations or duplication shall be made to the report template by Managed Care Plan. The Agency-supplied template to be used can be found on the Agency for Health Care Administration information web page at:

http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC/Report_Guides/Case_Management_File_Audit_Report.xls

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Chapter 17: Case Management Monitoring and Evaluation Report

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

Capitated Managed Care Plan Contract Type

LTC Plan Type

- LTC HMO
- LTC Capitated PSN

Fee-for-Service PSN Contract Type

LTC Plan Type

- LTC FFS PSN

REPORT PURPOSE:

The purpose of this report is to ensure that a system of internal monitoring of the case management program is in place and well documented.

FREQUENCY & DUE DATES:

This report is due quarterly within 30 calendar days after the end of the quarter.

An annual roll-up is due within 30 calendar days after the end of the 4th calendar quarter.

SUBMISSION:

Using the file naming convention described in Chapter 2, the Managed Care Plan shall submit the following to the SMMC SFTP site:

- Quarterly Case Management Monitoring and Evaluation Report using the template provided.
- A quarterly report attestation as described in Chapter 2.
- Annual Roll-Up of all calendar quarters using the same quarterly template provided.
- A report attestation as described in Chapter 2.

INSTRUCTIONS:

1. The Managed Care Plan shall create the Case Management Monitoring and Evaluation Report, both quarterly and annual roll-up, in the format and layout specified in the report template.

This shall include the results of:

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- a. Case file audits,
 - b. Reviews to determine the timeliness of enrollee assessments performed by case managers,
 - c. Reviews of the consistency of enrollee service authorizations performed by case managers, and
 - d. The development and implementation of continuous improvement strategies to address identified deficiencies.
2. The annual roll-up is separate from the fourth quarter report; however, both are due as specified under Frequency and Due Dates. The annual roll-up contains cumulative results from all calendar quarters.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency-supplied template must be used as specified in the Report Guide. No alterations or duplication shall be made to the report template by Managed Care Plan. The Agency-supplied template to be used can be found on the Agency for Health Care Administration information web page at:

http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC/Report_Guides/Case_Management_Monitoring_and_Evaluation_Report_04172013.xls

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Chapter 18: Case Manager Caseload Report

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

Capitated Managed Care Plan Contract Type

LTC Plan Type

- LTC HMO
- LTC Capitated PSN

Fee-for-Service PSN Contract Type

LTC Plan Type

- LTC FFS PSN

REPORT PURPOSE:

The purpose of this report is to ensure that enrollees are receiving quality case management services by monitoring the caseloads of case managers.

FREQUENCY & DUE DATES:

This report is due monthly, within 15 calendar days after the end of the reporting month.

SUBMISSION:

Using the file naming convention described in Chapter 2, the Managed Care Plan shall submit the following to the SMMC SFTP site:

- Case Manager Caseload Report using the template provided.
- A report attestation as described in Chapter 2.

INSTRUCTIONS:

1. The Managed Care Plan shall create the Case Manager Caseload Report in the format and layout specified in the report template.
2. For the reporting month, the report shall include the following, as specified by tab:

All case managers must be included in the Case Manager Caseload Report and can only be listed on one caseload tab of the report in addition to being reported on the Caseload Summary Tab.

Note that the template is formatted for five case managers per caseload type. The template is unlocked to allow for manual insertion of rows and columns to accommodate the Managed Care Plan's required reporting of all case managers.

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Community Caseload Tab:

- Case Manager's Name (First and Last)
- Enrollee Medicaid ID
- Enrollee Name (Last)
- Enrollee Social Security Number/SSN
- Total number of enrollees that reside in the community assigned to the case manager

Facility Caseload Tab:

- Case Manager's Name (First and Last)
- Enrollee Medicaid ID
- Enrollee Name (Last)
- Enrollee Social Security Number/SSN
- Total number of enrollees that reside in the facility assigned to the case manager

Mixed/Other Caseload Tab:

Only include case managers serving both enrollees in the Community and enrollees in the facility on the Mixed/Other Caseload Tab. Such case managers should not be included on the Community Caseload Tab or the Facility Caseload Tab.

For example, a case manager serves fifty-nine (59) enrollees that reside in the community and one (1) enrollee that resides in the facility. The case manager will be reported on the Mixed/Other Caseload Tab with the maximum mixed caseload of 60 enrollees.

- Case Manager's Name (First and Last)
- Enrollee Medicaid ID
- Enrollee Name (Last)
- Enrollee Social Security Number/SSN
- Total number of enrollees in multiple caseload types assigned to the case manager

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Caseload Summary Tab:

The number of case managers reported on the Caseload Summary Tab should match the combined number of case managers reported on the Community Caseload Tab, Facility Caseload Tab, and the Mixed/Other Caseload Tab.

- Case Manager's Name (First, Last)
- Total number of enrollees in the community, in the facility, and in multiple caseload types assigned to Case Manager

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency-supplied template must be used as specified in the Report Guide. No alterations or duplication shall be made to the report template by Managed Care Plan. The Agency-supplied template to be used can be found on the Agency for Health Care Administration information web page at:

http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC/Report_Guides/Case_Manager_Caseload_Report_Template_LTC.xls

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Chapter 19: Denial, Reduction, or Termination of Services Report

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

Capitated Managed Care Plan Contract Type

LTC Plan Type

- LTC HMO
- LTC Capitated PSN

Fee-for-Service PSN Contract Type

LTC Plan Type

- LTC FFS PSN

REPORT PURPOSE:

The purpose of this report is to monitor for trends in the amount and frequency that the Managed Care Plan denies, reduces, or terminates services, including both HCBS and nursing facility services.

FREQUENCY & DUE DATES:

This report is due monthly, within 15 calendar days after the end of the reporting month.

SUBMISSION:

Using the file naming convention described in Chapter 2, the Managed Care Plan shall submit the following to the SMMC SFTP site:

- Denial, Reduction, or Termination of Services Report using the template provided.
- A report attestation as described in Chapter 2.

INSTRUCTIONS:

1. The Managed Care Plan shall create the Denial, Reduction, or Termination of Services Report in the format and layout specified in the report template.
2. For the reporting month, the report shall include the following, as specified by tab, that occurs during the reporting month:

Denial of Services Tab:

- Enrollee's name (last, first)
- Enrollee's Medicaid ID
- Requested services (service name must be identical to service names as listed in Attachment II, Exhibit 5, Section V, Covered Services)
- Date of service denial during the reporting month
- Reason for denial using the numerical denial code specified in the template

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Reduction of Services Tab:

- Enrollee's name (last, first)
- Enrollee's Medicaid ID
- Previously authorized service
- Initial date of previously authorized service
- Previously authorized service amount and frequency
- Date of service reduction during the reporting month
- New service amount and frequency
- Reason for reduction using the numerical reduction code specified in the template

Note: services specified must be named identically to the service names as listed in Attachment II, Exhibit 5, Section V, Covered Services.

Termination of Services Tab:

- Enrollee's name (last, first)
- Enrollee's Medicaid ID
- Previously authorized service
- Initial date of previously authorized service
- Previously authorized service amount and frequency
- Date of service termination during the reporting month
- Reason for termination using the numerical termination code specified in the template

Note: services specified must be named identically to the service names as listed in Attachment II, Exhibit 5, Section V, Covered Services.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE

The Agency-supplied template must be used as specified in the Report Guide. No alterations or duplication shall be made to the report template by Managed Care Plan. The Agency-supplied template to be used can be found on the Agency for Health Care Administration information web page at:

http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC/Report_Guides/Case_Management_Caseload_Report_Template_LTC.xls

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Chapter 20: Enrollee Complaints, Grievances and Appeals Report

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

Capitated Managed Care Plan Contract Type

LTC Plan Type

- LTC HMO
- LTC Capitated PSN

Fee-for-Service PSN Contract Type

LTC Plan Type

- LTC FFS PSN

REPORT PURPOSE:

The purpose of this report is to provide documentation regarding any complaints, grievances, or appeals that have been submitted by enrollees to help ensure the needs of all enrollees are being adequately met and concerns are being addressed. This report may be used for monitoring issues that need to be addressed.

FREQUENCY & DUE DATES:

This report is due quarterly, within 15 calendar days after the end of the reporting quarter.

SUBMISSION:

Using the file naming convention described in Chapter 2, the Managed Care Plan shall submit the following to the SMMC SFTP site:

- Enrollee Complaints, Grievances and Appeals Report using the template provided.
- A report attestation as described in Chapter 2.

INSTRUCTIONS:

1. The Managed Care Plan shall create the Enrollee Complaints, Grievances and Appeals Report in the format and layout specified in the report template.
2. The template consists of seven worksheets (four of which are quarterly representations):
 - a. Instructions – explains how to complete the template.
 - b. Codes – provides report definitions and codes explaining the types of complaints, grievances, appeals and dispositions.

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- c. Quarter 1 through Quarter 4 – Each quarter has a separate worksheet for reporting complaints, grievances, and appeals received by the managed care plan during the reporting quarter.
- d. Summary – No data can be entered into the summary worksheet. As the managed care plan completes each quarterly worksheet, the data is captured and reported in the aggregate on the Summary worksheet.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency-supplied template must be used as specified in the Report Guide. No alterations or duplication shall be made to the report template by Managed Care Plan. The Agency-supplied template to be used can be found on the Agency for Health Care Administration information web page at:

http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC/Report_Guides/Enrollee_Complaint_Grievance_and_Appeals_Report.xls

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Chapter 21: Enrollee Roster and Facility Residence Report

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

Capitated Managed Care Plan Contract Type

LTC Plan Type

- LTC HMO
- LTC Capitated PSN

Fee-for-Service PSN Contract Type

LTC Plan Type

- LTC FFS PSN

REPORT PURPOSE:

The purpose of this report is to provide necessary information on the current physical location of each enrollee, and may be used for disaster recovery planning and recovery.

FREQUENCY & DUE DATES:

This report is due monthly, within 15 calendar days after the end of the reporting month.

SUBMISSION:

Using the file naming convention described in Chapter 2, the Managed Care Plan shall submit the following to the SMMC SFTP site:

- Enrollee Roster and Facility Residence Report using the template provided.
- A report attestation as described in Chapter 2.

INSTRUCTIONS:

1. This report must include all enrollees currently enrolled in the Managed Care Plan, including all Medicaid Pending enrollees, and the facility in which they are residing at the end of the reporting month, if applicable.
2. The Managed Care Plan shall create the Enrollee Roster and Facility Residence Report in the format and layout specified in the report template including the following information:
 - Managed Care Plan ID (Managed Care Plan three-character identifier from Chapter 2)
 - Enrollee's full name (last, first)
 - Enrollee's Medicaid ID
 - Enrollee's Social Security number
 - Enrollee's date of birth (mm/dd/yyyy)

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- Enrollee's physical address
- Enrollee's county of residence
- Type of facility (if applicable)
- Name of facility (if applicable)
- Facility License Number (if applicable)

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency-supplied template must be used as specified in the Report Guide. No alterations or duplication shall be made to the report template by Managed Care Plan. The Agency-supplied template to be used can be found on the Agency for Health Care Administration information web page at:

http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC/Report_Guides/Enrollee_Facility_Residence_Report.xls

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Chapter 22: Missed Services Report

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

Capitated Managed Care Plan Contract Type

LTC Plan Type

- LTC HMO
- LTC Capitated PSN

Fee-for-Service PSN Contract Type

LTC Plan Type

- LTC FFS PSN

REPORT PURPOSE:

The purpose of this report is to monitor all missed facility and non-facility services covered by the Managed Care Plan for the previous month in accordance with Attachment II, Exhibit 12, Reporting Requirements.

FREQUENCY & DUE DATES:

This report is due monthly, within 30 calendar days after the end of the reporting month.

SUBMISSION:

Using the file naming convention described in Chapter 2, the Managed Care Plan shall submit the following to the SMMC SFTP site:

- Missed Services Report using the template provided.
- A report attestation as described in Chapter 2.

INSTRUCTIONS:

1. The Managed Care Plan shall create the Missed Services Report in the format and layout specified in the report template. A missed service is defined as any authorized facility or non-facility covered service unit(s) that were not provided during the reported month.
2. Data to be reported includes but is not limited to the following:
 - Enrollee's full name
 - Enrollee Medicaid ID
 - Authorized service type
 - Authorized service units for the reported month
 - Number of authorized service units that were not provided in the reported month (missed service units)
 - Explanation and resolution of missed services

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VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency-supplied template must be used as specified in the Report Guide. No alterations or duplication shall be made to the report template by Managed Care Plan. The Agency-supplied template to be used can be found on the Agency for Health Care Administration information web page at:

http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC/Report_Guides/Missed_Services_Report.xls

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Chapter 23: Nursing Facility Transfer Report

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

Capitated Managed Care Plan Contract Type

LTC Plan Type

- LTC HMO
- LTC Capitated PSN

Fee-for-Service PSN Contract Type

LTC Plan Type

- LTC FFS PSN

REPORT PURPOSE:

The purpose of this report is to inform the enrollment management process, to monitor trends in transition from the nursing facility to the community and vice versa, and to monitor to ensure placements are safe and appropriate. The report is designed to track individuals that are transitioned out of nursing facilities into the community, as well as track individuals that are transitioned from the community into the nursing facilities.

FREQUENCY & DUE DATES:

This report is due monthly, within 15 calendar days after the end of the reporting month.

SUBMISSION:

Using the file naming convention described in Chapter 2, the Managed Care Plan shall submit the following Excel file to the SMMC SFTP site:

- Nursing Facility Transfer Report using the template provided.
- A report attestation as described in Chapter 2.

INSTRUCTIONS:

Nursing Facility Residents Transitioning to the Community

For nursing facility residents transitioning to the community during the reporting month, this report must include the following information:

- Managed Care Plan ID (Managed Care Plan three-character identifier from Chapter 2)
- Full name (last, first) of enrollee
- Enrollee's Medicaid ID
- Enrollee's Social Security number
- Enrollee's date of birth (mm/dd/yyyy)
- Enrollee's county of residence pre-community placement

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- Effective date of enrollment with the Managed Care Plan (mm/dd/yyyy)
- Date enrollee admitted to the nursing facility (mm/dd/yyyy)
- Name of nursing facility
- Nursing facility Medicaid provider number
- Date enrollee transitioned to the community (mm/dd/yyyy)
- Community residence (assisted living facility (ALF), adult family care home (AFCH) or enrollee's own/family home)
 - Street address
 - Name of residence (if applicable)
 - License number (if applicable)
- Name of the enrollee's county of residence post-community placement

Community Residents Transitioning to the Nursing Facility

For community residents transitioning to the nursing facility during the reporting month, this report must include the following information:

- Managed Care Plan ID (Managed Care Plan three-character identifier from Chapter 2)
- Full name (last, first) of enrollee
- Enrollee's Medicaid ID
- Enrollee's Social Security number
- Enrollee's date of birth (mm/dd/yyyy)
- Enrollee's county of residence pre-nursing facility placement
- Effective date of enrollment with the Managed Care Plan (mm/dd/yyyy)
- Name of nursing facility
- Name of the enrollee's county of residence post-nursing facility placement
- Nursing facility Medicaid provider number
- Date enrollee admitted to the nursing facility (mm/dd/yyyy)
- Community residence prior to nursing facility (assisted living facility (ALF), adult family care home (AFCH) or enrollee's own/family home)
 - Street address
 - Name of residence (if applicable)
 - License number (if applicable)
- Information regarding the enrollee's previous transition into the community from a nursing facility
- If previous transition occurred, date of previous transition (mm/dd/yyyy)

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

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REPORT TEMPLATE:

The Agency-supplied template must be used as specified in the Report Guide. No alterations or duplication shall be made to the report template by Managed Care Plan. The Agency-supplied template to be used can be found on the Agency for Health Care Administration information web page at:

http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC/Report_Guides/Nursing_Facility_Transfer_Report.xls

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Chapter 24: Participant Direction Option (PDO) Roster Report

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

Capitated Managed Care Plan Contract Type

LTC Plan Type

- LTC HMO
- LTC Capitated PSN

Fee-for-Service PSN Contract Type

LTC Plan Type

- LTC FFS PSN

REPORT PURPOSE:

The purpose of this report is to provide information about the total number of participants enrolled in and total number of participants who have discontinued participation from the Participant Direction Option (PDO). The report includes the PDO services provided to each participant, the PDO services that were discontinued during the report month and the reasons for discontinuing participation.

FREQUENCY & DUE DATES:

This report is due monthly, within 15 calendar days after the end of the reporting month.

SUBMISSION:

Using the file naming convention described in Chapter 2, the Managed Care Plan shall submit the following to the SMMC SFTP site:

- Participant Direction Option (PDO) Roster Report using the template provided.
- A report attestation as described in Chapter 2.

INSTRUCTIONS:

1. The Managed Care Plan shall create the Participant Direction Option (PDO) Roster Report in the format and layout specified in the report template.
2. For the reporting month, the report shall include a list of all PDO participants.
3. The report will also include any participants who disenrolled from the PDO for the month being reported and the reasons for discontinuing participation.
4. If a participant does not have any direct service workers receiving a paycheck for more than 30 calendar days, the participant should be reported as disenrolled from PDO.

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5. The report will include the PDO services that each PDO participant is currently receiving and the PDO services that the disenrolled participant was receiving up until disenrollment.
6. The following definitions, as defined in Contract, apply to this report:

Direct Service Worker --- An employee who is directly-hired by a participant to provide participant directed services as authorized on the participant's care plan. The direct service worker may be any qualified individual chosen by the participant including a neighbor, family member, or friend.

Participant -- An enrollee who has chosen to participate in the PDO, and who serves as the employer..

Participant Direction Option (PDO) — A service delivery option that enables enrollees to exercise decision-making authority and control over allowable services and how those services are delivered, including the ability to hire, supervise, and fire service providers. Under the PDO, the enrollee accepts responsibility for taking a direct role in managing his or her care.

PDO Services — The services an enrollee may choose to self-direct under the participant direction option. The five (5) services offered under the PDO include: adult companion care, attendant care, homemaker services, intermittent and skilled nursing, and personal care services. The Long-term Care Managed Care enrollee may choose to participate in the PDO for one or more of the PDO services as authorized in the enrollee's care plan.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency-supplied template must be used as specified in the Report Guide. No alterations or duplication shall be made to the report template by Managed Care Plan. The Agency-supplied template to be used can be found on the Agency for Health Care Administration information web page at:

http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC/PDO_Roster_and_Activities_Template.xls

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Chapter 25: Patient Responsibility Report

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

Capitated Managed Care Plan Contract Type

LTC Plan Type

- LTC HMO
- LTC Capitated PSN

Fee-for-Service PSN Contract Type

LTC Plan Type

- LTC FFS PSN

REPORT PURPOSE:

The purpose of this report is to provide a comparison of the total cost of home and community-based services (HCBS) to the enrollee's assigned patient responsibility amount for the prior Contract year.

FREQUENCY & DUE DATES:

This report is due annually, by October 1 for the prior Contract year.

SUBMISSION:

Using the file naming convention described in Chapter 2, the Managed Care Plan shall submit the following to the SMMC SFTP site:

- Patient Responsibility Report using the template provided.
- A report attestation as described in Chapter 2.

INSTRUCTIONS:

1. The Managed Care Plan shall create the Patient Responsibility Report in the format and layout specified in the report template.
2. Data to be reported includes the following:
 - Enrollee name
 - Enrollee Medicaid ID
 - Total patient responsibility amount
 - Total cost of home and community-based services enrollee received
 - Service(s) for which the Managed Care Plan and enrollee agreed that patient responsibility was/would be applied
 - Total cost of other Medicaid services enrollee received via the Managed Care Plan

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- Is the total cost of the HCBS received greater than or equal to the enrollee's patient responsibility amount?

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency-supplied template must be used as specified in the Report Guide. No alterations or duplication shall be made to the report template by Managed Care Plan. The Agency-supplied template to be used can be found on the Agency for Health Care Administration information web page at:

http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC/Report_Guides/Patient_Responsibility_Report_Ex_15_04172013.xls

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Chapter 26: Performance Measures Report LTC

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

Capitated Managed Care Plan Contract Type

LTC Plan Type

- LTC HMO
- LTC Capitated PSN

Fee-for-Service PSN Contract Type

LTC Plan Type

- LTC FFS PSN

REPORT PURPOSE:

The purpose of this report is to measure the Managed Care Plan's performance on specific Healthcare Effectiveness Data and Information Set (HEDIS) and Agency-defined indicators for the LTC program. This information is used to monitor and publicly report plan performance.

FREQUENCY & DUE DATES:

This report is due annually by July 1, for the prior calendar year.

SUBMISSION:

Using the file naming convention described in Chapter 2, the Managed Care Plan, through its qualified auditor, shall submit the following to the SMMC SFTP site:

- The Performance Measures Report.
- The HEDIS Auditor certification with Audit Review Table.
- A report attestation as described in Chapter 2. This attestation must include an attestation specifically addressing the accuracy and completeness of submitted information (where applicable).
- For Managed Care Plans generating an Interactive Data Submission System (IDSS) file as part of their HEDIS process, the Managed Care Plans shall submit the IDSS file with the Performance Measures Report.

INSTRUCTIONS:

The Managed Care Plan shall collect and report the following performance measures, certified via qualified auditor.

The Managed Care Plan must report the following performance measures each year to the Agency:

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HEDIS	
1	Care for Older Adults (COA): Add age bands: 18 to 60 years as of December 31 st of the measurement year ³ 61 to 65 years as of December 31 st of the measurement year ⁴ 66 years and older as of December 31 of the measurement year
2	Call Answer Timeliness (CAT)
Agency-Defined Measures	
3	Call Abandonment (CAB)- Using the last issued specifications from the National Committee for Quality Assurance (NCQA).
4	Required Record Documentation (RRD)
5	Face-To-Face Encounters (F2F)
6	Case Manager Training (CMT)
7	Timeliness of Services (TOS)
8	Prevalence of antipsychotic drug use in long-stay dementia residents
Survey –Based Measures	
9	CAHPS Nursing Home Survey — Long-Stay Resident: Staffing Composite (Items 10, 12-17)
10	CAHPS Nursing Home Survey — Long-Stay Resident: Recommend nursing home to others (Item 35)
11	Satisfaction with Long-term Care Plan: CAHPS Supplemental Question and Enrollee Satisfaction Survey Item 11
12	Satisfaction with Care Manager: CAHPS Supplemental Question and Enrollee Satisfaction Survey Item 5
13	Rating of Quality of Services: CAHPS Supplemental Question and Enrollee Satisfaction Survey: Item 8

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³ Agency addition to HEDIS

⁴ Agency addition to HEDIS

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1. The Managed Care Plan shall collect statewide data on enrollee Performance Measures, as defined by the Agency and as specified in Exhibit 8, the LTC Report Guide (as applicable) and Performance Measures Specifications Manual located at:

http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC/Report_Guides/Agency-Defined_Performance_Measure_Specifications_LTC.doc

2. Data must be aggregated by population.
3. For HEDIS and Agency-defined performance measures (PM), there is no rotation schedule. The Managed Care Plan must calculate and report each PM each year.
4. Data must be reported for every required data field for each PM. However, when the denominator is less than 30, report "*" (asterisk) in the "rate" field. For data fields other than "rate," report all data elements, including the numerator and denominator.
5. Extensions to the due date may be granted by the Agency for up to thirty (30) days and require a written request signed by the Managed Care Plan CEO or designee. The request must be received by the Agency before the report due date and the delay must be due to unforeseen and unforeseeable factors beyond the Managed Care Plan's control. Extensions will not be granted on oral requests.
6. Data Specifications – Each Managed Care Plan shall report the data elements described below for each of the required PMs.
 - a. Managed Care Plan Identification Number – The Medicaid ID number that identifies the plan, as assigned by the Agency for reporting purposes;
 - b. Performance Measure Identifier – The character code of the PM as specified in the table above in parentheses after the PM name;
 - c. Data Collection Method – The source of data and approach used in gathering the data for all PMs as specified by HEDIS or Agency definitions:
 1. Administrative method – Enter "1."
 2. Hybrid method – Enter "2."
 - d. Eligible Enrollee Population – The number of enrollees meeting the criteria as specified by HEDIS or Agency definitions;
 - e. Sample Size – Minimum required sample size as specified by HEDIS. This data element is not required if the administrative method is used. Leave blank (zero-fill) if c. above is 1;
 - f. Denominator – If the administrative method is used, eligible member population minus exclusions, if any, as specified by HEDIS or Agency definitions. If the hybrid method is used, the sample size is the denominator or as specified by HEDIS or Agency definitions;
 - g. Numerator – Number of numerator events from all data sources as specified by HEDIS or Agency definitions;
 - h. Rate – Numerator divided by denominator times 100.00;
 - i. Lower CI – Lower 95% confidence interval as specified by HEDIS. If the lower CI is less than zero, report 000.00. This statistic is to be calculated for all PMs;

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- j. Upper CI – Upper 95% confidence interval as specified by HEDIS. If the upper CI exceeds 100, report 100.00. This statistic is to be calculated for all PMs;
 - k. Format for Rate, Lower CI and Upper CI: Five digits with two decimal places required, right-justified; zero-fill leading digits; include decimal. Use the format: xxx.xx where x represents any digit and xxx is a value between 0 and 100.00.
7. All PMs must be certified by an NCQA-certified HEDIS auditor, to include both HEDIS and Agency-defined measures. **The Auditor must certify the actual file submitted to the Agency.** A statement of certification from the HEDIS Auditor that includes report designations for each performance measure must accompany the Managed Care Plan’s report submission.
 8. If the Managed Care Plan’s performance on Agency-defined and HEDIS performance measures is not acceptable and the Plan’s performance measure report is incomplete or contains inaccurate data, the Agency may sanction the Plan, in accordance with the provisions of Attachment II, Section XIV, Sanctions.
 9. A report, certification, or other information required for PM reporting is incomplete when it does not contain all data required by the Agency or when it contains inaccurate data. A report or certification is “false” if done or made with the knowledge of the preparer or a superior of the preparer that it contains information or data that is not true or not accurate.
 10. A Managed Care Plan that refuses to file, fails to timely file, or files a false or incomplete report or a report that cannot be certified, validated, or excludes other information required to be filed may be subject to administrative penalties pursuant to Section XIV, Sanctions, of the LTC Plan Model Contract provisions.
 11. A report that contains an “NR” due to bias for any or all measures by the HEDIS Auditor shall be considered deficient and will be subject to administrative penalties pursuant to Section XIV, Sanctions, of the LTC Plan Model Contract provisions.
 12. In the event that a performance measure is not applicable because the Managed Care Plan does not cover the service or the specific population being measured, the Managed Care Plan should indicate, “NB,” when reporting that measure.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

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REPORT TEMPLATE:

The Agency-supplied template must be used as specified in the Report Guide. No alterations or duplication shall be made to the report template by Managed Care Plan. The Agency-supplied template to be used can be found on the Agency for Health Care Administration information web page at:

http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC/Report_Guides/Performance_Measures_Report_Template_LTC.xls

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Chapter 27: Utilization Report

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

Capitated Managed Care Plan Contract Type

LTC Plan Type

- LTC HMO
- LTC Capitated PSN

Fee-for-Service PSN Contract Type

LTC Plan Type

- LTC FFS PSN

REPORT PURPOSE:

The purpose of this report is to enable the tracking of LTC Managed Care Plan enrollee service utilization, cost and demographic information including: the plan member's age, residential setting, presence of caregiver, and length of time enrolled with the plan. The report provides information about the service utilization of participants enrolled in and disenrolled from the LTC Managed Care Plan.

FREQUENCY & DUE DATES:

This report is due quarterly, within 30 calendar days after the end of the reporting quarter.

SUBMISSION:

Using the file naming convention described in Chapter 2, the Managed Care Plan shall submit the following to the SMMC SFTP site:

- Utilization Report using the template provided.
- A report attestation as described in Chapter 2.

INSTRUCTIONS:

1. The Managed Care Plan shall create the Utilization Report in the format and layout specified in the report template.
2. For the purpose of this report, the following populations shall be included in the participant count:
 - Home and Community-Based Services (HCBS): Services offered in the community setting designed to prevent or delay nursing facility placement of elderly or disabled adults. Document recipient services as listed in

SMMC Managed Care Plan Report Guide

Attachment I, Table 2 and as defined in Attachment II, Exhibit 5 (“Covered Services – LTC Plans”).

- Nursing facility: An institutional care facility that furnishes medical or allied inpatient care and services to individuals needing such services. (See Chapters 395 and 400, F.S.)
 - Hospice: Services are forms of palliative medical care and services designed to meet the physical, social, psychological, emotional and spiritual needs of terminally ill recipients and their families. Hospice care focuses on palliative care rather than curative care. An individual is considered to be terminally ill if he has a medical diagnosis with a life expectancy of six (6) months or less if the disease runs its normal course.
 - Identification of HCBS enrollees not using services
3. For the reporting quarter, the report shall include a list of enrollees receiving services from the Managed Care Plan. The report will include enrollee information, enrollee demographic information, services received, units of service, and actual expenditures.
 4. Each quarter, the Managed Care Plan shall include calendar year-to-date information as specified on the template.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency-supplied template must be used as specified in the Report Guide. No alterations or duplication shall be made to the report template by Managed Care Plan. The Agency-supplied template to be used can be found on the Agency for Health Care Administration information web page at:

http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC/Report_Guides/Utilization_Reporting_Template.xls

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